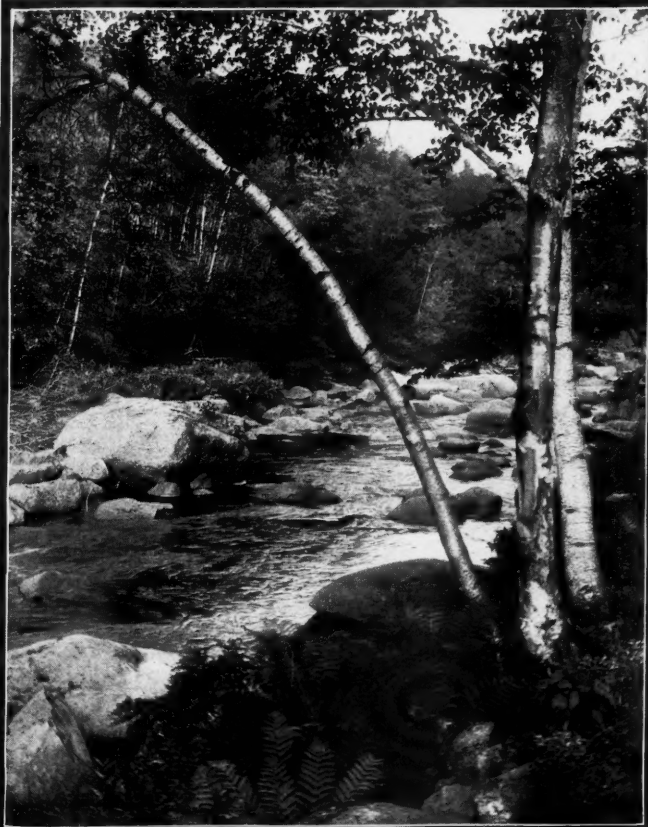


THE DENTAL DIGEST



APRIL - 1926

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First Issue—April, 1926

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THE DENTAL DIGEST

GEORGE WOOD CLAPP, D.D.S., EDITOR

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OUR COVER THIS MONTH

If you're a bit imaginative or poetical our cover picture might easily suggest to you in this balmy month of April a scene where Spring is registering joy as she "steps out" from the frozen bondage of Winter. The rivers now flow on unhindered, the trees sway in the gentle breezes, and buds and leaves begin to make their welcome appearance. "All nature seems at work, slugs leave their lair—the bees are stirring, birds are on the wing—and Winter slumbering in the open air wears on its sombre face a dream of Spring."

Our picture is a landscape view taken near Grafton, New Hampshire, the rock-ribbed State, where high mountains, pleasant valleys, babbling rivers, sky-blue lakes and forests primeval abound. Useful minerals are found in limited quantities, but the chief natural product is granite, a stone universally used for building purposes. This picturesque location is a visiting point for Summer tourists, where they easily find themselves in tune with the universe.

Dioxogen

Back in the year 1905 Prof. Wm. Osler said that in his opinion defective teeth cause more physical deterioration than alcohol.

The Volstead Act was designed to take care of alcohol, but defective teeth have no legal restriction; they may be possessed and even displayed with impunity.

That, however, does not lessen their danger, though perhaps these dangers are beginning to be recognized.

Defective teeth, dirty mouths, the germs and the germ poisons that are responsible for them are beginning to be appraised at their true value.

A prominent physician recently said that experience had convinced him that fatal pneumonia occurs with greater frequency among those with septic mouths than amongst those with clean mouths.

No one knows in just what condition his mouth may be—washing with plain water is not effective; repeated tests have proved this, and there is no evidence to show that flavored mouth washes are more valuable than water.

Bacteriological tests show that DIOXOGEN in one to four dilution in water destroys 95 to 98 per cent of the germs in the mouth.

A really clean mouth sometimes shows surprising results; chronic disorders and discomforts have been known to disappear and no one knows what benefits may be experienced if a personal trial has not been made.

DIOXOGEN as a mouth wash, to destroy germs and germ poisons, is really worthy of more than a passing thought.

To professional men who have not tried DIOXOGEN, a free sample will be gladly sent on request.



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NEW YORK, N. Y.

THE DENTAL DIGEST

Vol. XXXII

APRIL, 1926

No. 4

Differences Between Vincent's Infection of the Mouth and Suppurative Periodontoclasia (Pyorrhea) and Their Treatment*

By I. S. Miller, D.D.S., New York, N. Y., and Jersey City, N. J.

Chief, Periodontia Clinic, Midtown Hospital, New York, N. Y.

The purpose of this brief presentation is to call attention to the differential diagnosis of Vincent's infection of the mouth and suppurative periodontoclasia (pyorrhea), for many still mistake one for the other, and to emphasize the fact that pyorrhea is a preventable and curable disease, because most dentists still discourage their patients in the matter of a favorable prognosis in pyorrhea.

Vincent's infection of the acute type has the following characteristics: a fetid odor, a line of gangrenous tissue with a red line of demarcation, a marked destruction of the interproximal gingival papillae, easy hemorrhage, and marked tenderness and pain in the gum tissue. Fever is generally but not always present. There is usually an enlargement of the sublingual glands. There is a feeling of malaise and a metallic taste. It is contagious. There is an excessive flow of saliva.

In Vincent's infection of the sub-acute type the picture is much less severe than in the acute type. It looks like a typical case of gingivitis. The gingival margin is usually bright red and bleeding takes place easily. The sub-acute type may change to the acute type if conditions are favorable.

Unclean and unkept mouths are particularly disposed to Vincent's. It may occur at any age, but it is most frequently seen in patients between 18 and 30 years of age.

SUPPURATIVE PERIODONTOCLASIA

Suppurative periodontoclasia is rarely seen in people under twenty years of age. The teeth may or may not be loose. The marginal gingiva may or may not have receded. Deep pockets may be present, sometimes with tumefaction. The presence of pus can be demonstrated by pressure. Traumatic occlusion is invariably present. There is no pain or discomfort. Bleeding occurs only when the teeth are brushed. The

* From a clinic given before the First District Dental Society, New York, December, 1925; Eastern Dental Society, December, 1925; New Jersey State Dental Society, January, 1926; Ninth District Dental Society, New York, February, 1926.

extent of the alveolar resorption may be demonstrated in a radiograph. There is no fever and no systemic symptom.

A differential diagnosis between Vincent's angina and suppurative periodontoclasia depends upon the presence of odor, gangrenous tissue, fever and systemic symptoms, pain and easy bleeding and the results of microscopic examination.

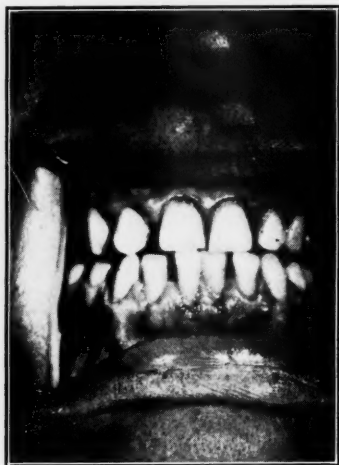


Fig. 1

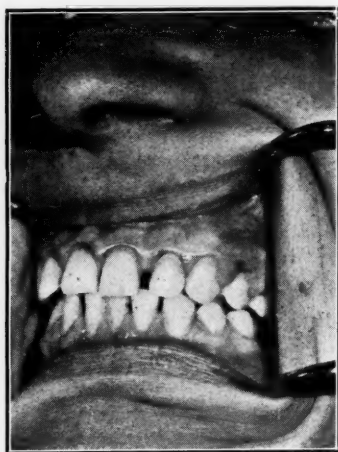


Fig. 2

Fig. 1. A case of suppurative periodontoclasia (pyorrhea) that had its inception in the loss of the mandibular left first molar and the maxillary right first and second premolars. The closing of the bite and spacing of the teeth which resulted caused an occlusal trauma extending from the right cuspids to the left second premolars in both jaws. This is typical of a large number of cases and affords a good argument for the conservation of the posterior teeth, particularly the six-year molars. The occlusal trauma is greatest at the mandibular centrals where vertical clefts (Stillman's clefts) are present in the marginal gingiva. Mobility was present in all the teeth in the affected region, but was greatest in the mandibular centrals and maxillary first left premolar. Recession can also be seen in various degrees. Thickening of the marginal gingiva and loss of its stippled appearance may be noted. Its glossy surface is plainly seen. A profusion of pus was present.

Fig. 2. Same case as in Fig. 1, showing tumefied interproximal gingival papilla between the maxillary left cuspid and the first premolar, which moved upward and forward a full millimeter in centric occlusion. A cleft can also be seen here.

TREATMENT OF VINCENT'S INFECTION OF THE MOUTH

The treatment of Vincent's infection of the mouth, after diagnosis is established, consists in attacking the microorganisms with a solu-

tion of one teaspoonful of sodium perborate in three-quarters of a glass of lukewarm water used as a mouth wash every half hour. Sodium perborate should be purchased only in original packages and the solution should be made fresh each time it is used. Also, the grayish yellow deposits should be removed carefully with tapering swabs of bibulous paper by the operator's going gently interproximally into the craterlike space toward the crest of the alveolus. Bibulous paper is used because of its superior absorbent quality. A ten per cent solution of salvarsan in glycerine is then applied to the lesion, care being taken not to cause any undue pressure upon the gingiva. Instrumentation is contra-indicated at this time, as is also the extraction of any teeth. The patient must refrain from smoking and eating hard foods.

Within twenty-four hours, usually, the severity of the symptoms is markedly lessened and the patient experiences a sense of relief. The

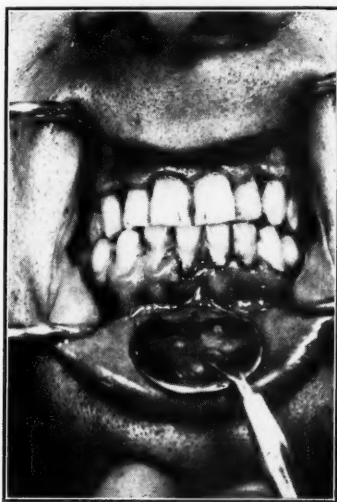


Fig. 3. Typical appearance of the marginal gingiva in Vincent's infection of the mouth. The interproximal papillae (gingivae) principally are attacked, and in this case many are completely destroyed because food debris accumulates in larger quantities interproximally in the unclean and neglected mouth, the type of mouth generally attacked by the spirillum and fusiform bacilli of Vincent. Blood can be noticed at the gingival margin of the mandibular right central and interproximally at the right maxillary lateral and cuspid. Vincent's infection of the mouth has resulted fatally in a number of cases.

treatment at the chair must be applied daily until the interproximal gingiva starts to regenerate. Then the case may be seen less fre-

quently, but the importance of keeping the mouth scrupulously clean should be impressed upon the patient. The food debris must not be permitted to remain interproximally. The spirillum and fusiform

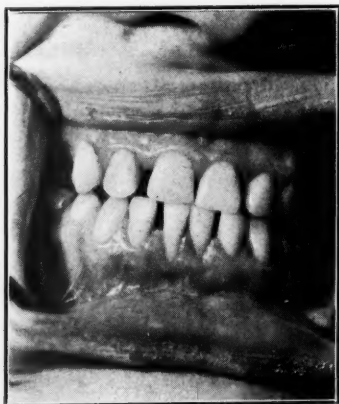


Fig. 4. Suppurative periodontoclasia (pyorrhea), same case as shown in Figs. 1 and 2, after treatment was completed. Suppuration ceased, teeth became firm. No drugs were employed to accomplish this.

bacillus of Vincent thrive in decaying organic matter. Removal of calculus is done in easy stages after the acute symptoms have all disappeared. All other mechanical irritants are removed and traumatic occlusion relieved. Cases should be watched for about two months before being finally dismissed.

Intravenous injection of salvarsan is sometimes resorted to in Vincent's infection of the mouth. Some operators claim that this is the most effective treatment, due to the difficulty of eradicating the Vincent's organisms from the system by mere local treatment.

TREATMENT OF SUPPURATIVE PERIODONTOCLASIA

Clinical management of pyorrhea, after the diagnosis is made and the chief symptoms are recorded, consists first in the establishment of harmony in the occlusion. It is often necessary to do some judicious grinding of both restorations and natural teeth in disharmony. A knowledge of dental anatomy and normal occlusion serves one well here. Accurate models made of the complete mouth are most helpful. The next step is the removal of deposits. To accomplish this, a definite technic must be adopted and then mastered. It is not easy to do this, but it is absolutely essential for success.

Permit me to suggest that the best way to learn proper instrumen-

tation is to have an experienced periodontist demonstrate the technic on a patient. The speaker has found *that* to be the quickest way to learn really how to achieve success with these cases.

At this juncture in the treatment it will be found that suppuration has ceased and loose teeth become firm in the great majority of cases, the exceptions being those where pocket formation is irregular in shape about single-rooted teeth or where they extend beyond the bifurcation in multi-rooted teeth. In these cases, where there is enough of the alveolar process remaining to cover about one-half of the root, and where all teeth are present, it is advisable to resort to the flap or open-view operation.



Fig. 5. Same case of Vincent's infection of the mouth as shown in Fig. 3, after treatment. Note the beginning of the regeneration of the interdental papillae distal to the maxillary centrals. Treatment of these cases should continue until this point is reached. There is an urgent necessity for careful hygiene of the mouth in order to permit the complete regeneration of this tissue.

The next and final step in the treatment of suppurative periodontoclasia is gingival stimulation. This is best accomplished by means of the toothbrush. The method of physical culture of the gingiva, as demonstrated by Dr. Stillman, has been adopted by the writer. The patient must be drilled in this until he has mastered it. No drugs are necessary to arrest suppuration and are contra-indicated in the treatment of suppurative periodontoclasia.

It is wrong for the general practitioner to tell the patient that pyorrhea cannot be cured. It is well to remember that, no matter how far advanced a case may be, at one point in its course it could have been arrested.

665 Fifth Avenue, New York, N. Y.

100 Montgomery Street, Jersey City, N. J.

Preparing a Vital Tooth for a Jacket Crown*

By H. Spalding Both, D.D.S., New York, N. Y.

The use of porcelain jacket crowns for the restoration of vital teeth has been subjected to the severest tests of experience, and the results have won for them an established place in the procedure of many exacting operators. It is far easier to make a satisfactory jacket crown where it is indicated than to make a well-fitting inlay for a complicated case.

The indications for this form of restoration are usually so clear as to make detailed discussion of the point unnecessary. Among the classes of teeth for which the jacket crown is particularly adapted may be mentioned the following:

1. Anterior teeth destroyed by caries, especially when these carious areas involve one or both approximating sides and when the incisal edge is involved.
2. Discolored teeth.
3. Teeth broken off by accident.
4. Teeth with unsightly or imperfect fillings.
5. Teeth in faulty alignment or occlusion.
6. Teeth where a filling would be of questionable duration.

These are the types most commonly encountered. Others might be included. Bicuspid and molars are suitable for this treatment where a costly gold inlay might be objectionable. Devitalized molars offer ideal subjects, but inasmuch as this paper is to deal with vital teeth only, the technic for this type of tooth will not be described.

PREPARATION

Many methods, varying in detail, may be suggested and used with equally good results. The method here described has proved its worth in the hands of a large number of operators. The technic is as follows:

A roentgenogram of the tooth is obtained to determine the size and the shape of the pulp, especially of that part situated in the coronal portion. This shows any abnormalities of the pulp chamber, such as horns running far into the dentine, the thickness of the enamel, the extent of the caries, and whether or not pathological conditions exist in and around the environments of the tooth. A pulp test also may be made.

An impression is taken of the tooth with modeling compound. This is forced well around all the surfaces of the adjacent teeth, and a model

* From a motion-picture clinic given before the First District Dental Society, New York, December, 1925. The Society for Cinematographic Instruction in Medicine and Surgery, 152 West 42d Street, New York, is the producer and distributor of the film.

is poured for study purposes and for future reference in working out the detailed characteristics of the tooth.

Before starting the actual tooth preparation, it is essential to keep the picture of what is to be finally accomplished vividly in mind. The prepared tooth stump should be in miniature a replica of the original



Fig. 1

IDEAL TOOTH PREPARATION

Before starting on the tooth, it is essential that the operator have a vivid picture in his mind's eye of the finished preparation. Notice breadth of shoulder to length of tooth.

tooth. This must be continually kept in mind. If the proper procedure is followed, many vital teeth—I might say, most vital teeth—can be prepared without the use of conductive or infiltration anesthesia. I always attempt to prepare a tooth in this manner.

With a safe-sided separating disk $\frac{7}{8}$ inch in diameter running at high speed, and with little pressure under a continuous stream of warm water, the mesial and distal enamel is quickly removed. The triangular pieces of enamel so cut are then readily broken or chipped off at the cervix with a suitable chisel. When this has been accomplished, the sides of the tooth should be parallel, converging but slightly toward the incisal.

The tooth is now shortened about a quarter with a mounted stone No. 11, the stone being kept wet, without pressure and at high speed, and following the general direction of the original incisal edge, but planing the surface to withstand the stress of incision in the best possible way.

The next step is to remove *all* the enamel from the tooth. This is essential, as will be seen later. Most dentists find the use of enamel cleavers the most satisfactory. Before the cleavers are used, however, the enamel is cut into little diamonds with a small knife-edged stone. The stone cuts through the enamel at the neck of the tooth, following



Fig. 2

CUTTING DIAMOND-SHAPED AREAS

Remove *all* the enamel from the tooth. With a knife-edged stone, cut the enamel into little diamond-shaped areas on both the labial and the palatal surfaces.

the cervical margin, on both the labial and the palatal surfaces, the approximating surfaces having already been cut. Great care must be taken not to cut into the dentine. Little diamonds are then made all over the labial and the palatal surfaces, as the cuts are made first in a mesio-distal and then in an inciso-gingival direction. On the palatal side the cuts are usually made more oblique. The enamel so cut readily yields to enamel cleavers and is rapidly denuded from the tooth. Care must be taken not to remove any of the dentine, for, as you all know, the more tooth that remains after allowing for the thickness of the porcelain, the more protection is given the pulp and the more nearly



Fig. 3

DENUDING

The enamel thus cut yields readily to enamel cleavers and is rapidly denuded from the tooth. Notice enamel lying on the finger and the instrument.

is the natural condition approached. The importance of sacrificing as little tooth structure as possible cannot be overemphasized.

With subgingival enamel cleavers the enamel under this delicate tissue is very carefully removed. At this time, and at this time only, is the copper band fitted. A very handy selection of seamless copper bands or tubes in twenty different diameters, $\frac{1}{2}$ inch long and of 30-gauge, may be procured at any dental depot. The proper diameter, one that fits rather snugly, is selected, trimmed and festooned to follow the gingival margin, much in the manner of the gold shell crown. The trimmed edge is smoothed off with a fine stone to avoid laceration of the gingiva. Only one band need be fitted. This is now laid aside.

The making of the shoulder is the next step. If all the enamel has been removed from the tooth—and I cannot stress this point too strongly—the cutting of the shoulder in the softer dentine becomes a very simple matter. It is just as important to know what to avoid as it is to know what to do. The shoulder should not be too broad; if it is, it will be necessary to sacrifice a lot of dentine from the remaining sides of the tooth. With a No. 57 fissure bur, cutting the shoulder begins at one definite point, usually at the disto-labial part in a left upper incisor and at the mesio-labial part in a right upper incisor. The handpiece is held firmly with the four fingers and palm, with the thumb resting securely on the incisal or occlusal surface of a convenient adjoining tooth. Care should be exercised not to lacerate the delicate gingival mucosa or peridental membrane with the bur. This can be avoided by starting to make the shoulder at the free margin of the gum, and not under it, and, with a lateral sweeping motion, by gradually cutting in an apical direction with the end of the bur and in a pulpal direction with the side of the bur, exerting little pressure on the instrument and avoiding the creation of thermal shock. The engine handpiece should always be held with the fissure bur at right angles to the floor of the seat and not parallel to the long axis of the tooth. This assures a continuous smooth shoulder without pits or steps. The bur should not be held in one spot but should be swept gradually over the labial and the palatal surfaces. The breadth of the shoulder should never be as great as the diameter of the Size 57 bur. One must be guided in some measure, of course, by the size of the tooth to be worked upon. For instance, in lower anteriors the shoulder is a mere suggestion and is much narrower than in an upper central or cuspid. The narrower the shoulder, with the strength still maintained, the less dentine will obviously need to be removed from the remainder of the crown and the more ideal will be the operation.

The shoulder has now been cut in one continuous line about one millimeter below the free margin of the gum and all around the tooth. After it is certain that the seat is completed in one definite, continuous

line, the shoulder is trimmed up with a narrow chisel or with files of convenient size, so that the floor is perfectly smooth and at a sharp right angle to the conical stump now remaining and flaring slightly outward toward the periphery.

The tooth is now polished with cuttlefish disks, then washed and dried with alcohol, and painted with a cavity lining, such as rosin and chloroform. This is very important. The cavity lining is now dried with hot air. The importance of sealing the dentinal tubuli before submitting the dentine to the tremendous pressure of the modeling compound is apparent. We all know how drugs, dyes, etc., can be forced through dentine under pressure, and we should therefore not force the bacteria-laden saliva into the healthy dentine. Accordingly, this should be done before the actual impression is taken.

TAKING THE IMPRESSION OF THE TOOTH

The previously fitted copper band is now placed back on the prepared tooth. As the palatal side of our original tooth is quite differently shaped from the labial, so should the preparation differ. It is not necessary, therefore, to mark the labial side of the copper band. The



Fig. 4

TAKING THE IMPRESSION

The previously fitted copper band is replaced on the tooth, which should now be approximately two-thirds of the original size. After placing the band slightly beyond the shoulder, hold it in position with thumb and index finger of the left hand. Slightly vaseline the fingers of the right hand and heat compound cone so that the tip is very soft and the consistency is cooler and more unyielding toward the base.

two surfaces will look so entirely different that no error can occur in the subsequent amalgam dye.

The band is now accurately placed on the tooth, reaching slightly beyond the shoulder. It is held in position with the thumb and index

finger of the left hand, while a small or medium-sized modeling compound cone is warmed over a small Bunsen flame with the right hand. These cones come in three different sizes. The size best adapted for the size of the band should be selected and heated so that the tip is soft and the consistency of the modeling compound is more and more cool and unyielding toward the base of the cone. The fingers of the right hand are vaselined to keep the mass from adhering to the fingers.

The copper band is placed on the tooth first without the modeling compound because if the band is forced on the tooth with the compound in it, it will get stuck at some point on the shoulder. This will produce a faulty and incomplete impression of the shoulder and no impression whatsoever of the root just slightly beyond the shoulder.

The impression is now chilled with cold water or cold air and carefully removed from the tooth, with the aid of a small napkin, in a direction with the long axis and general direction of the tooth. The impression is dried out and inspected to see whether a perfect impression, including the entire shoulder, has been obtained. An impression of the tooth root for perhaps half a millimeter beyond the shoulder should also be obtained.

The bite is now taken by furnishing some tin foil over the opposing teeth and covering this with a strip of softened baseplate wax. A small piece of baseplate wax about one inch square is softened and shaped into a cone. It is forced upon the prepared tooth and well adapted to it; over this and the surrounding teeth is placed a soft strip of baseplate wax. The patient is now asked to close the mouth in normal occlusion and, while the mouth is so closed, to force the wax against the palatal and lingual aspects of the teeth with the tongue, while the operator manipulates the labial aspect of the wax with his fingers. After this is chilled and removed from the mouth, the bite is dried and reinforced with sticky wax.

The taking of the impression can be done in many ways. Some operators prefer to take a second ferrule impression of the tooth in modeling compound and, while this remains in position, to take a plaster impression. Others take plain modeling compound or plaster impressions without the copper band impression. I prefer to take an impression in baseplate wax. The degree of accuracy of the impression with this material depends considerably upon the manner in which it is heated. The bulk of the wax should be fairly hard. It is placed in a suitable impression tray and the surface is then well heated over a Bunsen flame and placed in the mouth, care being taken to include the corresponding tooth on the opposite side in this impression. I prefer the wax impression because the amalgam dye will fit into it with the least possibility of being wrongly placed mesio-distally, bucco-palatally or mesio-gingivally.

The plaster impression over the ferrule modeling compound impression is undoubtedly very accurate, but I have often experienced difficulty in placing the amalgam dye poured in one impression accurately into a second impression. Using the same ferrule impressions for the dye as well as for the plaster impression is more desirable, but this deprives the operator of examining the modeling compound impression until after the plaster impression is completed.

TAKING THE SHADE

Volumes have been written and could still be written about taking the shade. The ceramic worker should always strive to imitate the general and specific characteristics of the tooth. This phase of the work is at least as important as the correct color. The degree of convexity of the labial surface, the mesial and the distal outline, the size of the interproximal space, the peculiarities in the formation of developmental grooves at the cervix, stains and the formation of discolored secondary dentine at the incisal edge such as is found in elderly people whose teeth are worn by attrition, the rotated effect of laterals and many other little details should be worked out to give the maximum result in esthetics. I have made hundreds of shades with various combinations of porcelain. I have baked central facings to match the different standard shade guides. The purchasing of large quantities of porcelain of a certain shade at one time eliminates any variation in this particular color. This part of the subject takes us too far into the subject of the baking of the crown and does not, therefore, come properly under this heading.

Take the shade with the guide with which you are most familiar and with which you can reproduce the color with the porcelain you are using. Some men use the shade guides supplied by the manufacturers of the porcelain. When this is done, the tooth must be divided into sections and each section matched with the particular color best adapted.

PROTECTING THE TOOTH DURING THE INTERVAL OF CONSTRUCTION

Here again many different methods with varying degrees of satisfaction have been devised. For vital teeth I invariably use baseplate gutta-percha rolled up in a cone and adapted to the tooth, trimming it with hot instruments to make it resemble the original tooth. The gutta-percha is carefully trimmed at the cervical margin so as not to go beyond the shoulder. After this is chilled, it is removed and cemented on the tooth. The covering affords a very comfortable protection for the tooth.

OPERATIVE AND MECHANIC TECHNIC INTERLOCK

The operative part of the procedure so interlocks with the prosthetic

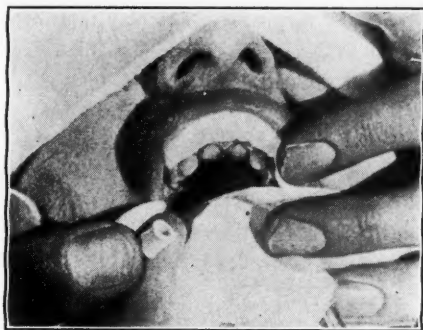


Fig. 5

PROTECTION OF TOOTH DURING INTERVAL

During interval of making of the jacket, protect tooth with baseplate gutta-percha formed into a hollow roll.

that it is obvious to all ceramic workers that the best results are obtained when the operative part and the technical part are done in close cooperation with each other. A crown baked in a laboratory, even if the laboratory is most skillful and conscientious, rarely gives the best results. Every dentist can make a better crown after a little practice.

The crown should be fitted in the mouth just prior to putting on the final bake and before the platinum hood or matrix is removed from it. At this time a careful examination is made of the cervical fit, the contact point, occlusion, etc. The matrix is now removed and the crown washed and dried with alcohol. The tooth is made ready for the

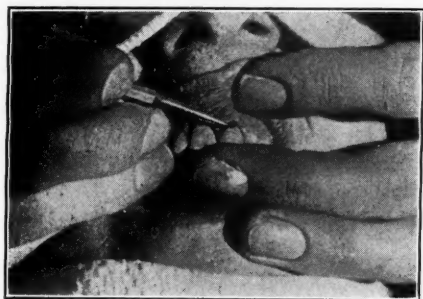


Fig. 6

TRY IN BISCUITED JACKET

Try in biscuited jacket crown with matrix to examine for cervical fit, contact point, occlusion, etc. *Always* fit jacket crown before removing platinum matrix.

reception of the jacket by drying with alcohol and again painting with rosin and chloroform. The jacket is lined with a creamy mixture of cement and gently forced upon the tooth.

The color of the cement is a very important problem. Many beautiful jackets have altered their shade by the color of the cement. This is particularly true if the labial part of the crown is thin and therefore very translucent. The salient point to remember is that a light-colored cement seems to have the least effect on the jacket and therefore cream white or white cement is most suitable. The cement may first be mixed with water for a try-in, if the operator wishes to assure himself of the result. Should it be desirable to darken the color of the jacket, a darker cement should naturally be chosen. After the cement has set, the surplus is chipped away and the cervical joint polished with strips.



Fig. 7
FINISHED JACKETS

CONCLUSION

In this paper I have tried to give merely a brief resumé of the operation. Many deviations which are naturally developed during long practice are omitted, for the operative procedure is usually altered to the individual's need and adaptability. It is difficult to picture a technic vividly with words only and pictures. Illustrations, diagrams, etc., often tell the story much more impressively and accurately. The actual preparation of a vital upper central incisor according to the foregoing technic is shown by means of a motion picture film. This is perhaps the most accurate, interesting and vivid method at our disposal. As the simplicity of this technic gains wider recognition, I feel that it will greatly stimulate interest in this method of treatment which has produced highly gratifying results for so many operators.

576 Fifth Avenue.

Occlusion—The Fundamental Element In Dental Science

By Paul R. Stillman, D.D.S., F.A.C.D., F.A.A.P., New York, N. Y.

(Continued from March)

Sign No. 13. Stillman's Clefts. These are clefts occurring in the gingival border, occasionally in the center line of the tooth but more commonly to one side of this line. Two clefts are frequently noted on the same tooth. Although the underlying tooth surface may not be visible, due to the apposition of the divided tissue, it is invariably



Fig. 13

Sign No. 13. Stillman's Clefts. This "sign" can be seen in the photograph over the cuspid in a "one o'clock" location.

possible to pass an instrument through any portion of the cleft to the tooth surface. The writer regards these clefts as essentially small pockets in which the ulcerative process has extended through to the labial surface of the gingiva.

Sign No. 14. Absence of Stippling. In the normal gingiva the color is not a uniform pink, but presents a translucent, stippled appearance of alternating spots of lighter and darker shade. When the normal gingiva is dried, it presents a somewhat velvety or mossy surface, indicative, apparently, of a normal circulation in the capillary loops. There is frequently observed a condition in which this mossy, stippled appearance is lost and the surface is shiny, even when dried,

and of a uniform color. The author considers this usually to be a sign of edema in the gingiva.



Fig. 14

Sign No. 14. Absence of Stippling. This print illustrates very perfectly Sign No. 14. Note the shine on the gingiva on the lower labial over the two central incisors.

Sign No. 15. Festoons. When, through the action of a certain grouping of etiologic factors, a hyperclasia of the marginal gingiva is induced, it is frequently manifested clinically by the occurrence of a linear depression outlining the marginal gingiva. The marginal gingiva presents a characteristic uniform thickening, which, however, in the

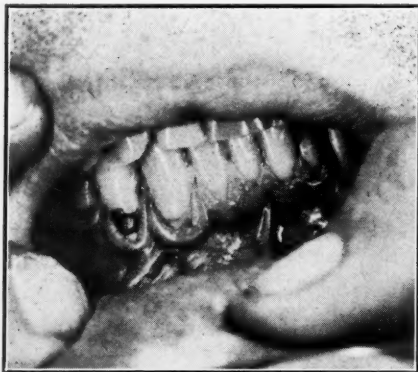


Fig. 15

Sign No. 15. Festoons. Festoons are shown in Fig. 15 about the lower cuspid gingiva. Fig. 13 also shows these festoons.

early stages, does not involve the margin itself. In the early stages, too, there is no deviation from the normal color. McCall has called attention to the frequent relationship between these festoons and traumatic occlusion.

Sign No. 16. Injection of Blood Vessels in the Marginal Gingiva. With the aid of an ordinary magnifying glass there is to be seen, in many cases, a typical dilatation of the blood vessels in the gingival margin. This is to be considered as an indication of early infection in the marginal gingiva.



Fig. 16

Sign No. 16. Injection of Blood Vessels in the Marginal Gingiva. This "sign" is preliminary to *Sign No. 2—Congestion of Marginal Gingiva*. Without a glass all that can be seen in this picture is a narrow dark line on the marginal gingiva of the lower right central incisor. It is really an incipient marginal gingivitis.

Sign No. 17. Increased Depth of the Gingival Crevice. The normal gingival crevice measures in the average case approximately two millimeters. Any increase in its depth beyond this point must be regarded with suspicion. It is to be regarded as a sign of early pocket formation in the cemental gingiva. This lesion is to be detected only by the use of a suitable diagnostic probe.

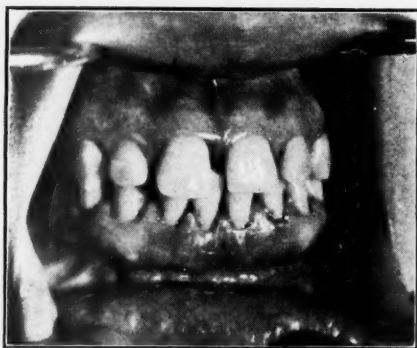


Fig. 17

Sign No. 17. Increased Depth of the Gingival Crev-
ice. Note the right upper central incisor's gingival
border. At ten and two o'clock on the curve of the
gingival margin there are breaks in its continuity. These
breaks indicate pocket formation.

Sign No. 18. Epithelial Nodules. There are occasionally to be
seen on the surface of the gingivae small, slightly elevated nodules.
They are of a lighter color than the surrounding tissue, and in shape
are usually round or oval. They usually indicate a period of long-
standing venous congestion.



Fig. 18

Sign No. 18. Epithelial Nodules. The epithelial
nodules may be seen on the alveolar gingiva of the right
lower cuspid. They are not common.

Sign No. 19. Distended Veins in the Mucosa. In many cases there
are to be observed dilated blood vessels of purplish color arising in the
septal cemental gingiva and traceable for a considerable distance in

the alveolar mucosa. They usually indicate the establishment of infection in the cemental gingiva at the base of the interproximal crevice.

Fig. 19

Sign No. 19. Distended Veins in the Mucosa. No illustration is available to show these distended veins. They are very common, however, but do not photograph well.

Sign No. 20. Pus Cells in the Crevicular Exudate. Frequently, when clinical signs of pus are lacking and the gingival crevice is of normal depth, a microscopic examination of the crevicular fluid will reveal the presence of pus cells. This may safely be regarded as evidence of a suppurative gingivitis.

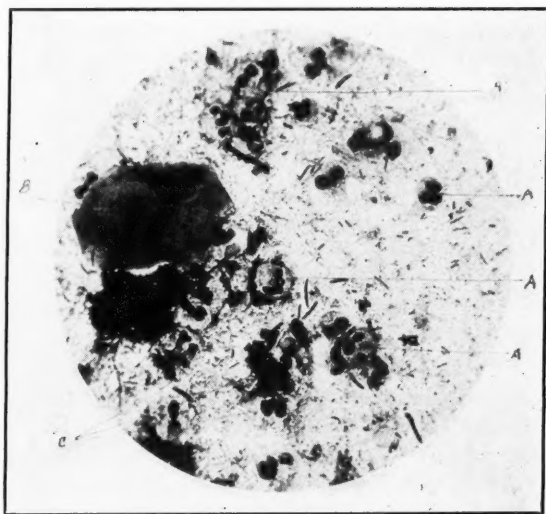


Fig. 20 (a)

Sign No. 20. Pus Cells in the Crevicular Exudate. A—Pus cells, chiefly polymorphonuclear leucocytes. B—Epithelial cell from the gingiva. C—Fragments of nuclei of degenerated leucocytes. Note the numerous bacteria—many fusiform bacilli and delicate spirillum, denoting Vincent's infection.

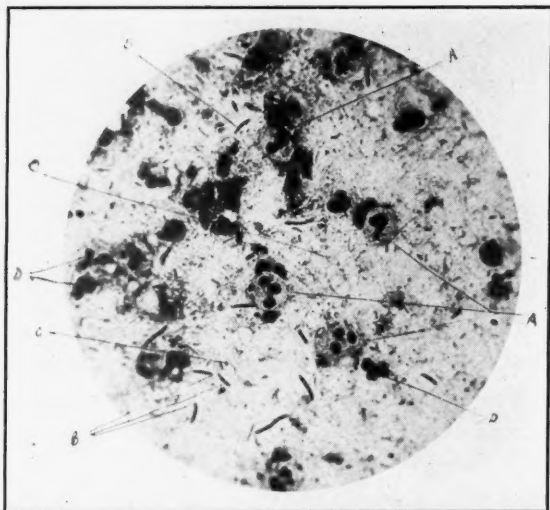


Fig. 20 (b)

Sign No. 20. Pus Cells in the Crevicular Exudate. (From photomicrograph by Harold Keith Box.) A—Necrotic polymorphonuclear leucocytes (dead pus cells); note the clover-leaf nuclei. B—Fusiform bacillus. C—Spirillum. D—Nuclear fragments of pus cells.

There may be some among you who will not agree with my recommendation that occlusal adjustment be made before clinical evidence of disease is apparent. Surely none will dispute, however, the dictum that traumatic occlusion should be corrected as soon as even one of these twenty signs appears, for many of these abnormalities have been definitely ascertained to be diagnostic of a fairly advanced state in the development of rarefying pericementitis fibrosa.

It may occur to you that I am developing my subject in a somewhat one-sided manner, but, unfortunately, the subject of occlusion is too broad to cover acceptably in a single paper. It may be well to make it clear, however, that I hold convictions on the relationship of physiologic occlusion to the health of the teeth themselves, as well as of the periodontium. As yet, these beliefs have not been carried to a point where I can support them with proof. I shall, therefore, make no extended comment on this phase of the subject. I can, however, speak with some authority on the relationship existing between traumatic occlusion and certain disturbances of the alveolar nerves and the dental pulp. My experience in this field has been rather extensive and entirely convincing.

I have often found mouths in which there was evidence of traumatic occlusion with, however, little or perhaps no clinical evidence of disease of the periodontium. But in these same mouths there have been striking and usually painful manifestations of a disturbance in the nervous system of the parts. The simplest form is a pulpitis exhibiting undue sensitiveness to thermal changes. Neuralgia, in any of the branches of the fifth nerve, may occur, even with symptoms of pain simulating tic douloureux. In a paper recently published I described several of these cases and shall not take time here to discuss them.* Since writing that paper, however, I have treated a case which illustrates the relationship of traumatic occlusion to this form of disease in a very striking manner. A description of this case follows:

Mr. G., aged 67 years, presented with symptoms of tic douloureux on the right side of the face. Previous dental history good. There was a generalized chronic infection of the gingivae, but only two or three deep pockets. The general occlusal arrangement was good, the teeth being almost immune to caries. The patient had recently had two lower molars extracted in an effort to overcome his painful affliction, but without success. The pain was most severe in the region of the temporal bone. There was also tenderness to touch over the mental foramen and at the right angles of the mouth. Spasm of the muscles was frequent. I found on examination that there was a slight traumatic occlusion throughout the mouth, but without advanced periodontal disease on the lower right side. It was, however, the lower right first bicuspid and first molar to which the origin of his pain was referred. The radiograph failed to reveal any abnormality other than what appeared to be a calcific degeneration of the pulp of these teeth; there was no convincing evidence of pulp stones.

Treatment consisted of balancing the occlusion throughout the mouth, with especial relief and rest for the lower right first bicuspid and first molar. The result of the first treatment was practically a complete cessation of the tic. There was a continuation of a slight, dull, intermittent pain referred to the mental region, gradually diminishing, however, until at the end of six weeks the patient reported entire comfort. The novelty and success of this treatment aroused considerable interest among the physicians whom the patient had consulted and who had previously agreed that only an injection of alcohol in the ganglia would give him relief.

Sensitiveness at the neck of the tooth and sensations usually interpreted by the patient as indicating cavity formation are often due to traumatic occlusion. Were any of you to visit my office, you might be astonished to see the variety of abnormal conditions of the teeth and

* *The Varied Reactions to Traumatic Occlusion—Journal of American Dental Association*, July, 1924.

their supporting structures which are found to be attributable, in whole or in part, to traumatic occlusion. These cases are treated in large part by balancing the occlusal relation.

52 Vanderbilt Avenue.

(To be continued)

Ex-Service Men and Women

You are familiar with renewable term (war time) insurance, the reason for its coming into existence and the benefits derived therefrom, but do you know that you can still reinstate this insurance at a very low cost and that the last date upon which you may reinstate and convert your insurance expires on July 2, 1926?

Do you know that you may live where you please, follow any occupation you choose without increasing your premium rates?

Do you know that after one year you can borrow 94% of the cash value?

Do you know that there is no legal reserve level premium—participating insurance providing equal benefits with an equal guarantee of safety offered at a premium rate as low as the Government rates?

Do you realize that these policies are backed by the Treasury of the United States?

The Government has made exceptionally liberal provisions for reinstatement and conversion.

Special facilities have been arranged in all of the Regional Offices of the United States Veterans' Bureau throughout the country for rendering every possible assistance to those desiring to reinstate and convert their insurance, including physical examinations free of charge.

Don't Procrastinate—Act Now!

Government Insurance is the wisest, safest investment you can make. If you wait until next week, you may be ill and therefore a poor risk.

Act Today!



Making Two Sets of Teeth Last a Lifetime

By W. A. Allen, D.D.S., Billings, Montana

Twenty years ago I began to experiment with the deciduous teeth of children with the intention of retaining the entire set, both uppers and lowers, without decay or blemish, until they were replaced by the permanent set, with the idea of the permanent set absorbing the entire roots of the deciduous teeth, thereby doing away with extracting any part of the first set.

The permanent or second set absorbs the mineral contents of the first, which consist of:

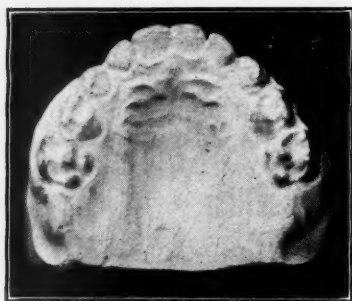
Phosphates and fluoride calcium	89.82%
Carbonate of calcium	4.37%
Phosphate of magnesium	1.38%
Other salts88%
Cartilage	3.39%
Fat20%

By the retention of this deciduous set we keep the jaw normal in size and thus prevent the crowding of the arch, since there is room for proper occlusion.

This process of making two sets of teeth last the patient a lifetime will cause many skeptical persons to scoff and sneer, just as they did concerning wireless telegraphy and the Panama Canal before they became actual realities. Even bridgework in its infancy was condemned by two-thirds of the dental profession. Today three-fourths of the entire profession will say that pyorrhea *can be checked but not cured*. This is absurd. I have some patients who commenced this two-sets-for-life system twenty years ago. Forty years ago pyorrhea was the exception. Today the person who has perfect teeth is the exception.

My inspiration came to me when I was examining the teeth of an old Crow Indian chief, Pretty Eagle, ninety-five years of age, straight as an arrow and six feet two in his bare feet. He had thirty-two teeth in his mouth worn down almost to the gums, but not a cavity could be seen in the entire set.

My method will call for more dentists who can start to treat the teeth in fetal life. If the child is fed with proper food, rich in minerals which prevent bone disease, his teeth will be good. The care of the teeth should start at birth. The mother should drink lime water, as this affords protection to the teeth of the child in later life. The temporary teeth should never be extracted. If this is done, the jaws will contract, thus starting malocclusion.



No. 1

Model from child of 4 years. Mother was treated before birth of child and child has been treated since birth. Twenty teeth present without a cavity or stain. Upper part of vault was imperfect in the impression for this model.



No. 2

Models from a patient now 18 years old. His parents are small and at the age of seven years his jaws and mouth were of less than normal size. He has been regularly treated by the author's methods.

Twenty years ago I began practice according to these principles, and the results were entirely satisfactory.

There are three clearly defined steps in this method. First, it is necessary to furnish the mother a combination of foods which supply certain necessary elements. There is considerable difficulty in assembling these elements one by one, but it is possible to assemble them in such way as to make administration easy if the preparation is palatable. Secondly, there should be a mechanical device consisting of a soft rubber pad attached to a strong cord, with a snap at the end. Two such snaps may be fastened to opposite ends of a rope, and with the soft pads between the teeth children may be encouraged to pull against each other as in a tug-of-war. Thirdly, there should be proper nourishment and exercise until the permanent set is developed. This procedure will cause the two sets to last a lifetime; also, it will add from ten to fifteen years to a patient's life. We wish to lay stress on the foundation during the fetal period, as the effects will last through the entire life of the patient. No other treatment will compensate for the loss or lack of a foundation.

Let us commence at the foundation and build up, instead of beginning at the effect and building down. Dr. Mayo said very wisely, "Prevention, not cure." Dr. C. N. Johnson advises the same thing. We are on the trail—let's get results! This process, in two generations from now, will astound even the most skeptical men in our profession.

225 Fratt Building



Localization

By Joel M. Zametkin, D.D.S., Brooklyn, N. Y.

(Continued from March)

In the Stereoscopic Method, we make use of our double vision habitually fused as one, so that we forget that we are using two eyes. Stereoscopy depends upon the intrinsic ability of the optic center to see an object from two different angles and at the same time fuse it into one object as if it were directly in front of *one* eye, incidentally

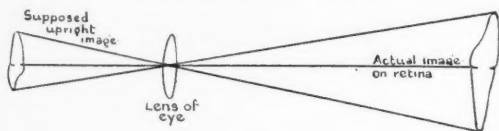


Fig. 9

cheating our sense of vision by actually "seeing" the object upside down and straightening it out for us, so to speak. (Fig. 9.)

When an object is looked at, it is observed along the equal sides of an isosceles triangle, a triangle two sides of which are equal. The base, always the unequal side, is invariably two and a half inches long; and this regardless of how far or near the object may be. This base is in reality the distance between the centers of the pupils of the eyes and is known as the pupillary distance. (Fig. 10.) Stereoscopy is

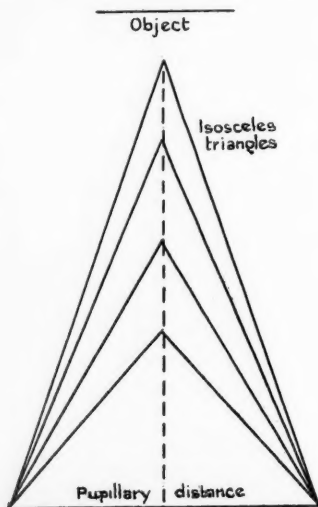
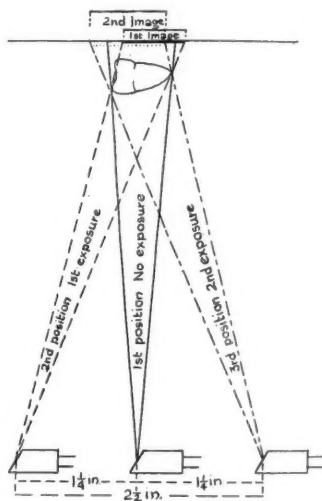


Fig. 10

merely a mechanical repetition with an instrument to imitate what the eyes do, the former in two distinct steps, the latter in one by means of that peculiar ability of the optic center to fuse the images. To forestall any possible argument, let it be understood here that we can also sight any object without the isosceles triangle by moving the eyeballs only, but in order not to confuse, and to explain stereoscopy better, let us think in terms of the isosceles triangle; otherwise we delve into very intricate optics.

Stereoscopic radiographs are made as follows. The patient, film and tube are posed as if one radiograph were to be made by the standard method. Without any change of position of patient and film



Note the common portion of the image and the little extra on each end because of the shifting of the tube.

Fig. 11A

the tube is swung one and one-quarter inches to the left and directed at the tooth. The first exposure is made. The patient remains immovable, but a second film is placed in the exact position of the first. The tube, remaining in the same plane, is now swung to the right two and one-half inches and pointed at the same spot as the first exposure. The films are developed and prints made, if the lens stereoscope is used; if not, the developed films suffice, but a transillumination stereoscope must be employed. Whichever method is used, the images must coincide and must also be centered and placed in the same planes. Realize that we must imitate actual vision, otherwise the whole procedure is a failure. To illustrate:

Figure 11a will be understood upon a moment's study. Note, however, the common portion of the tooth that both positions of the tube

cover (that embraced in the bracket) and the little extra that each tube includes. It is these slight differences that each eye sees and that the stereoscope fuses about the common portion which give the illusion of depth to the stereoscope radiograph. It is to be noted that Figure 11b is only a fusing of the Shift Method, first left and then right. Recall that in the Shift Method the hindmost tooth sprang to the viewing eye. It follows that when the two Shift Methods are fused in the stereoscope, there occurs the illusion that each picture springs to its viewing eye with the consequence of the sensation of centering, and what is seen in centering is the mutual portion of the tooth (Fig. 11a) and the blending of the little extra on either side. The result is the sensation of three dimensions, which brings us to the test of triangulation.

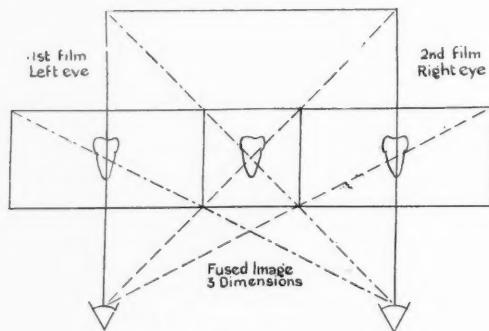


Fig. 11B

When the picture is viewed in the stereoscope, a point in the foreground may be selected, and another in the background. The background is to the left of the foreground, so that, following the arrows in order of number, we again arrive at the two coinciding arrowheads (Fig. 12). One has but to see a stereographic radiograph in a stereoscope to realize its depth and "stand-outed-ness," and the ease with which the pictures prove the diagram and the diagram the pictures. As a caution, however, there is failure ahead with this method if one neglects the points of identical duplication with each step, except the shifting of the tube one and one-quarter inches to the left and then to the right from the centering point. As an experiment, line up the index fingers one in front of the other with both eyes open, centering vision on the rear finger. Note that it is very difficult to hide the rear finger completely with the forefinger, because the left eye sees a little of the rear finger around the front finger, so to speak—first shift; the right eye does the same but from the opposite side—second shift.

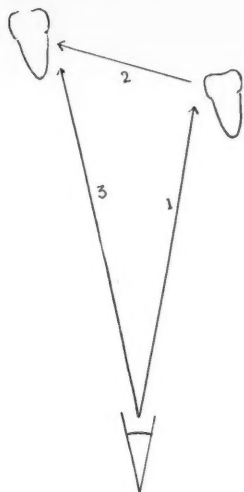


Fig. 12

The fourth method is that of Opacity. The technic is very simple but very unreliable and should not be used as a sole guide; as a check-up it has its place. The Opacity Method depends on a source of light and the shadows cast by an object on a screen. A radiograph is taken of a tooth in the standard way, the film is developed and the position of the tooth must be determined by the intensity of the shadow cast, that is, whether the tooth is in labial or palatal position. As a further explanation, let me record the conclusion of a number of shadow experiments: (1) the shadow is sharpest and nearest in size to the object when the object and the screen are in actual contact; (2) the shadow becomes more blurred as the screen is moved away from the object; (3) the shadow becomes blurred as the object is moved toward the light; (4) moving the light to the object casts a blurred shadow on the screen. Therefore it becomes possible to decide from the quality of the shadow whether one or the other object is hindmost. Mind, however, that here we are dealing with solid objects and ordinary light, which does not penetrate.

The question becomes more complicated with radiography. The x-ray now not only penetrates in varying degrees, dependent upon the density of the object, but affects the film in a great variety of tones from the deepest black to the lightest gray. Besides, it must not be forgotten that the two objects (the visible tooth and the hidden one) and the screen (the film) are in close contact, with the result that it becomes well nigh impossible to draw positive conclusions. One has

but to try shadow-casting through bits of clear glass, frosted glass, opal glass, using solid objects in different positions in relation to the screen, to the light, to each other through the glasses mentioned to realize how futile and bewildering localization becomes, let alone the penetrability of the object with a penetrating ray on a film at best giving hazy conclusions. Although this method is not very reliable, it does not invalidate the triangulation test. The principle remains intact and can be demonstrated (Fig.13).

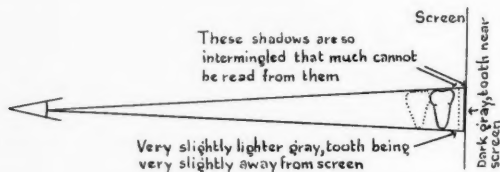


Fig. 13

The triangle lies in the fact that the dark spot with any point in its shadow is hindmost, while the light spot with any point in its shadow is foremost, left or right (Fig.14). Therefore it behooves us to select a dark spot and a light spot far apart, in itself not so easy, in

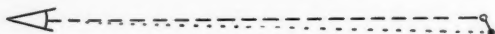


Fig. 14

order to construct a decided triangle (Fig. 15). Because it is so very difficult to be sure that the dark spot in the shadow is the rear object, and not the front object, triangulation becomes difficult, and therefore the conclusions are vague. Were it possible to cause the sides of the

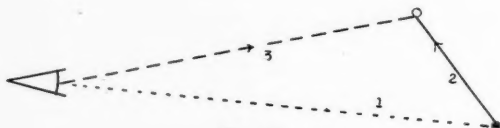


Fig. 15

triangle to diverge greatly, then localization would become simple. Since the other methods permit of this divergence in varying degrees, the conclusions are more positive.

We are now ready to look into the fifth method, the Objective Method. One can scarcely honor this procedure by name of "method." The tooth's position is actually seen. The conditions about the area

indicate that you see the tooth, you see an enlargement, you feel the tooth by palpation. One hardly need go into this method any farther than to say, "I see the tooth."

In conclusion, bear in mind that we are triangulating so often and so automatically that we do not realize it at all. Watch a young child as it learns to do things. In its early days it tries to develop the sense of position, but does so very poorly, with the consequence that it pokes its spoonful of food now into its cheek, more often into its eye, not neglecting its nose, chin and ears, with the result that baby's face is a mess with one clear spot—its mouth—an untouched bull's eye. How differently, twenty years later, does he do a series of swiftly changing triangulations of varying magnitudes, in running fast after a rapidly moving car to board it skillfully, with right foot on step, left and right hands neatly placed on the grasp rail! Who of us has not done this? Triangulation!! Most assuredly, not single nor double, but multiple—eye, rail and hand; eye, foot and step; eye, feet and ground; eye, car and surroundings; etc., etc. Practice!! But what a miserable failure in triangulation in rifle practice—dozens of shots and the target untouched! Poor triangulation—that's all!

We are accustomed to wide triangulations. We have been doing them all our lives. In rifle practice the eye, sight and object must coincide. The two sides of the triangle must be depressed and made to coincide with the base. Here we have the extreme, obliterating the triangle into a straight line, exactly as children do in playing "hide and go seek"—getting behind objects, depressing two sides into the base to confuse the seeker, while he in turn runs about changing his triangles, trying to alter the hidden one's straight line into a triangle. Many examples might be given, but the point to bear in mind is that the more divergent the sides of the triangle are, the more readily can the object be located.

If the reader will give thought to the Bite Plane Method and compare it with the other methods, he will note that it is the best method because the triangle for localization is at its extreme divergence from the point of vision.

16 Court Street.



Togo's "Discursions"

Mr. Editor of Digestible Dentistry:

Hon. Sir:

April are month consisting of All Fools day & 29 others in which work so conscientiously started may be allowed to proceed as far as possible.

Subject of fools, Mr Editor, embraces large area of varied & interesting territory much of which has been profitably studied & cultivated by those not so afflicted. Even in limited area of delightful dental practice large assortment of Fools may be readily perceived & commented upon though complete classification is perhaps impossible as all species are closely allied.

Convenient start may be made by brief visit to office of Hon Doc Oldtimer which is usually at head of dingy unswept stairway on off side of Main St. Appearance of reception room would cause tears of rejoicing in eyes of Antique dealer from Boston but only sneers of pity from ordinary mortal seeking somewhat sanitary dental services.

Ventilation was foreign subject which designer of Oldtimer's office had perhaps never heard of & Hon Doc has preserved with utmost care all original atmosphere furnished by landlord when lease was signed on day following assassination of Pres. Garfield.

Condition of equipment in operating room is even more overpowering if possible. Appearance of cuspidor makes nauseating announcement that everybody is doing it, though state of wall paper on side line furnishes proof that some are suffering from faulty trajectory due to wide variety of causes.

Greasy look of headrest pads causes intelligent patient to speculate as to shortest possible route of egress from premises once first sitting has been successfully survived. Description of office of Hon Oldtimer could be extended to fill entire magazine, Mr. Editor, but Fools of other descriptions should be mentioned in order to avoid appearance of playing favorites.

At opposite end of exhibit is highly colored and superbly polished specimen only recently arrived in professional family and therefore still greatly impressed with self-importance. Hon Superdock is fine-looking chap much of which he has done himself or purchased at barber shop or other convenient service station.

Reception room of this gentleman contains last word and several future whispers regarding "perfect appointments." Everything in entire layout seems to be chanting modern refrain of "excessive overhead." Hon Superdock is tremendously pleased with himself & the refrain sung by expensive & impressive surroundings is music to his

ears. "High pressure" is one of his favorite terms; he conducts his life by its use in his practice & it will finally cause his death at an early age by actually entering into the condition of his life blood.

Superdock is one who misses all the best things in life because continually trying to substitute something else just as good. For honest professional advice he substitutes salesmanship and self-interest; for worthy charity he substitutes new system of cost accounting which impresses fact that operating costs were first accurately described by Poet Laureate of England who observed with regard to purling brook that it "went on forever."

In between two extreme brands of fools enumerated exist several less distinguished varieties, Mr. Editor, some of which may be briefly commented upon.

There is still largely surviving the timid operator who does not believe that the principle of "extension for prevention" should be carried out absolutely & honestly in every problem involving decay of approximal surfaces of molar & bicuspid teeth.

There is the tooth destroyer who carelessly constructs ill fitting partial plates because so mentally obese that he fails to comprehend the damage which they do or so muscularly clumsy that he is unable to construct anything requiring real manual dexterity.

There are the operators who dismiss patients as having mouths in complete state of health when presence of tartar can be easily observed by intelligent layman at distance of ten feet by employing either visual or olfactory apparatus furnished as standard equipment to all human beings.

There are faddists of every kind, many of them delightful men of remarkable personalities who by force of unusual mentality could make successful business of retailing cracked ice to Esquimaux.

Avoiding all brands of foolishness enumerated, Mr. Editor, Hon. Average Practitioner D.D.S. must steer his way to modest success. To avoid all forms of foolishness is perhaps impossible for mere human being but at least sincere effort can be attempted to make low & somewhat creditable score the general rule.

Hoping you are the same,

Togo.



Scouting for Boys

By Ray O. Wyland

Department of Education, Boy Scouts of America, New York, N. Y.

Never was there such a wide interest in the boyhood of the nation as is now manifest among business men of all groups. There is a sudden realization that boys are the stuff we make men out of, and that the influences which play upon boy life are as vital as the elements which enter into heredity. Dr. George Vincent has truly said that heredity and environment are as the two blades of the scissors—no one can tell which does the cutting.

The most rapidly growing movement in the world is the Boy Scout Movement. It is now celebrating its sixteenth birthday in America. In this short span of years more than three million men and boys have benefited by its Program. Scouting has also reached out to the nations of the world, so that the sun in all its course never ceases to shine upon the uniform of the Boy Scouts. About fifty-six nations have Scout organizations, yet half of the Scout population of the world is in America. In the last International Jamboree, held in Copenhagen, August, 1924, the Boy Scouts of America won the highest honors on a competitive basis in Scouting activity.

There are today nearly 700,000 active Boy Scouts under the leadership of 170,000 volunteer workers. Scouting has placed upon the fathers in the community a responsibility for the boys of the community. The volunteer plan is both economical and effective. Less than 800 professional Scout executives are giving leadership to this great army of volunteers who serve hundreds of thousands of Boy Scouts.

There must be a reason for the unusual vitality of this national and international boy movement. Scouting will go only as far as men will take it, and it can remain only where boys want it. Its acceptance among the boys and men of all nations is proof that it satisfies the boy and is deemed of sufficient value to the men so that they are willing to give time and leadership to its promotion.

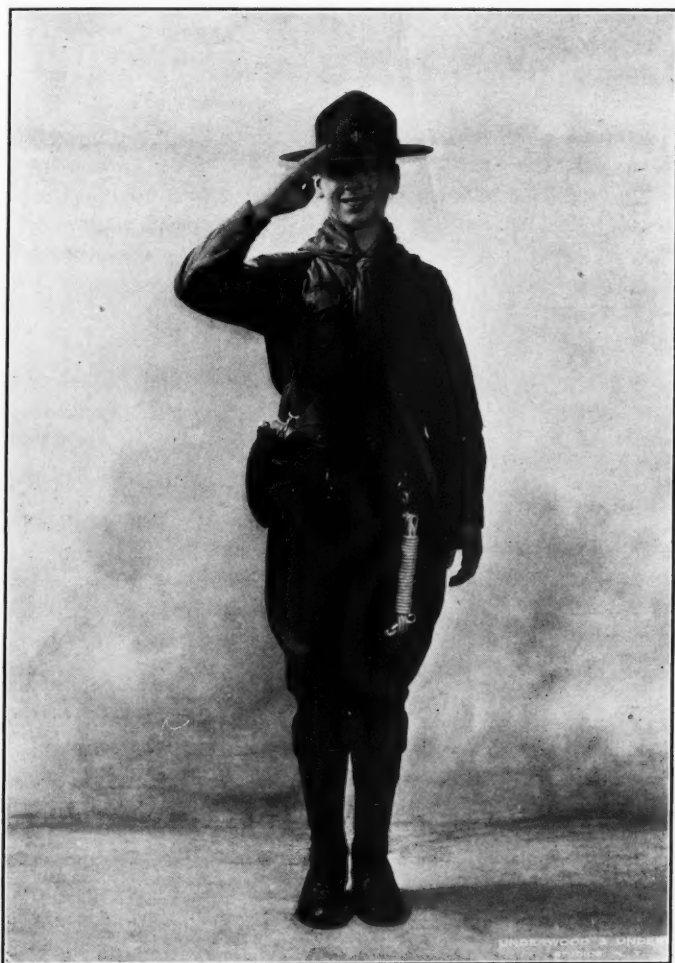
SCOUTING AS BOYS SEE IT

There are five definite reasons why Scouting appeals to boys:

(1) The outdoor features—cooking, camping and hiking, nature lore, canoeing, swimming, life-saving, map-making, and various types of construction work in camps, cabins, shanties, etc.—appeal to the red-blooded boy and to many a boy who would be red-blooded if he could enjoy the life in the open. In the summer of 1925, 273,000 boys spent from a week to a month in one or another of the great number of Boy Scout camps scattered throughout the United States.

(2) Boys are interested in the competition between patrols, or little "gangs," which are organized in the Scout troops. Patrol projects and competition for efficiency form a major feature in the program of the troop. The boy wants his "gang" to win. Team play and co-operation are essential features of a good boy program.

(3) Boys are interested in the helpful facts, information and skill which they derive from the Scouting Program. The boy progresses in



A TENDERFOOT SCOUT

successive stages from Tenderfoot, through Second Class, First Class, Star, Life, and Eagle Scout rank. All that he learns from his Tenderfoot tests to his Eagle Scout badge is calculated to increase his efficiency for community service and his mastery over things and the environment in which he lives. The motto of Scouting is: "Learn by doing." A Scout is not only informed; he is skilled in the subjects of first aid, life-saving, swimming, map-making, outdoor life, etc.

(4) The boy is interested in the fun which he derives from a well-balanced Scout Program. Whenever a boy goes home from a meeting saying, "We had no fun this time," that meeting was a failure. There must be a place for games, songs, stunts, competitions, ceremonies, camp fires, initiations, etc., and a program that grips the red-blooded boy.

(5) The major factor in Scouting which grips the boy, and from which he derives the greatest benefit, is fellowship with other boys and with men of good character in a program of activity that is gathered around a group ideal such as is expressed in the Scout Oath and Law. We shall discuss these later in connection with the elements in the Scout Program that appeal to men.

SCOUTING AS MEN SEE IT

Men are interested in Scouting not as mere child's play, or as a camping program, but because of the permanent benefit which the boy derives from Scouting activity. These benefits may be very readily classified as follows:

(1) A program in the outdoors, under the open sky and in the fresh air, which brings the boy into daily contact with woodland and stream, together with the vigorous exercise of hiking, camping and canoeing, is calculated to develop a strong, robust body. The conditions under which Scouts live in the open are similar to the conditions of the pioneer life on the frontier which produced the strong manhood that conquered the wilderness and laid the foundations of our present civilization and prosperity.

The Boy Scout is taught also the laws of social health and hygiene, public health and sanitation. He takes care of his teeth and his diet. He breathes fresh air. He keeps his body clean. He knows the value of health, and he observes the laws which make for good health. He is also a guardian of the public health.

(2) Men are interested in Scouting for the vocational guidance which boys derive from their experimentation with 73 merit badge subjects, covering as many of the arts, trades, sciences and professions. It is not the intention of the merit badge project to equip a boy for his life work or to turn out a master mechanic or electrician. The aim is to help the boy discover his natural gift and to awaken an

ambition to develop himself along the line of his native endowment. In this connection it is of interest to know that the Boy Scouts, who total less than one-tenth of the boys of Scout age in America, have been able to register an enrollment ranging from one-third to one-half, and in some instances as high as 60% and 70%, of the student bodies in



DANIEL CARTER BEARD
National Scout Commissioner

our American universities and colleges. The percentage of Scout enrollment in some of our major universities in 1925 was as follows:

Harvard, 49%; Yale, 38%; Lafayette, 52%; West Point, 56%; Northwestern, 50%; University of Michigan, 44%; University of Oregon, 40%; Washington and Jefferson, 64%; Beloit, 72%.

During the same period a letter was sent out to thirty-two Cecil Rhodes scholars. Twenty-eight replied. Of this number fifteen were former Scouts. It would appear that Scouting is dealing with the boys who are going on to higher education to prepare to be leaders in the life of this nation.

(3) Men are interested in Scouting because of the clean reading program that it provides through the service of its library and publications department. An effort has been made to provide literature which has the elements of romance and an appeal of gripping interest to the boy, that is also free from any taint and from advertisements of any product that would be injurious to the boy.

(4) Men are interested in Scouting because of the citizenship training which boys get from the philosophy and the practice of the Scouting Program. We now refer to the wholesome attitude toward life, which is more important than technical skill. Far better that a boy should remain ignorant and honest than be skilled and a criminal. Scouting aims to give the boy a wholesome attitude toward life's obligations. These ideals are expressed in the Oath and Law and are carried out in the daily good turn. "Be prepared" is the motto. The daily good turn is the Scout habit. If his training as a Scout equips him for service—and the ideals of a Scout provide a motive for service—the daily good turn produces the habit of service.

(5) Men are interested in Scouting for a more basic reason, as it relates to the whole field of character education. How will you help a boy to develop a character that stands four-square? You can't rub the virtues into his skin. You don't get it by telling a moralizing story. It doesn't come with a formula that is committed to memory. We arrive here at the same element which makes the Scout Program attractive to the boy, namely, the fellowship with other boys and with good men. There are three features in this Program which bear directly upon the character-building influences in the boy's life:

First, there is the ideal of the Scout Oath, which recognizes duty to God and country, to others and to self. There is also the code of a Scout as expressed in the Scout Laws—a Scout is trustworthy, loyal, helpful, friendly, courteous, kind, obedient, cheerful, thrifty, brave, clean, reverent. We do not say a Scout must be trustworthy. We assume that he is, and it is a compliment to the boy that we assume it. Unconsciously the boy also assumes that he is trustworthy, adopts this standard as his code of ethics, and lives up to it. In his mind he may say: "I am a Scout. A Scout is trustworthy. Therefore I must be trustworthy."

More influential than the Scout Oath and Law is the influence of the gang, or group morale, or standard of conduct. What the group decides to do is the proper thing to do. Every boy in the group will

maintain that standard. When the group has established its ideal on the plane of the Scout Oath and Law, the influence of the group will lift every boy to that level. The new boy coming into this group rises to the level of the group morale previously established. Scouting does not fear the "gang" as a destructive thing. A "gang" neglected may be destructive, but a "gang" directed is a constructive force in the lives of boys.

The third element in the character-building program is the influence and fellowship of good men who are worthy to be an example to the boys with whom they work. Every boy consciously, or unconsciously, sets before his mind's eye or in the picture gallery of his ideals the vision of the man that he is going to be. That man has a face like yours or some other man that he knows. Possibly every man has some boy in tow. If you are a true man, you are a strength to the boy. If you are not a true man, you are a stumbling block in his way.

The genius of the Scout Program is manifest in its ability to recruit and train the best men in the community to give leadership to boys in the community in a program of activities that grips those boys, allows ample room for self-improvement, the development of projects and gang life, all the while wielding an influence over the lives of those boys by virtue of what the man himself is. If we can fashion the ideals of the rising generation by the standard of the best manhood of this generation under the influence of the best executives that our civilization has produced, we shall have in the next generation a standard of manhood of which no one need to be ashamed. They will keep our flag in the sky, and they will preserve our leadership among the nations of the world as a power for righteousness and democracy.



The Dental Society of the State of New York

PRELIMINARY PROGRAM

The 58th annual meeting of the Dental Society of the State of New York will be held at the Hotel Astor, New York City, May 19-22, 1926.

The literary exercises, clinics and exhibits will be held at the Hotel Astor. Dr. A. C. Bennett, 576 Fifth Avenue, New York City, is Chairman of the Exhibits Committee. Dr. Frederick R. Adams, 8 West 40th Street, New York City, is Chairman of the Clinic Committee.

The Executive Council will convene for the transaction of the business of the Society at 10:00 A. M., Wednesday, May 19, 1926.

Educational courses will be given on May 17, 18 and 19, prior to the regular session of the State Society. Applications for registration in Courses One and Two, Extraction and Anesthesia, should be made to Dr. Adolph Berger, 10 East 74th Street, New York City. Applications for the other courses, consisting of Root Canal Therapy, Radiography, Dental Ceramics, Shoulder Crowns, the Use of Porcelain, Removable Bridgework, Movable Removable Bridgework, Dental Anatomy, Fixed Bridgework, Various Technics Essential to Bridgework, Full Denture Construction, Partial Denture Construction, the Treatment of Periodontoclasia and Orthodontia, should be made to Dr. Edward Kennedy, 347 Fifth Avenue, New York City. Full information with reference to these courses will be furnished on application. A cordial invitation is extended to the members of other State Societies to avail themselves of the opportunity to take these educational courses.

LITERARY PROGRAM

May 19, 20, 21, 22, 1926

A New Research on Dental Caries. Percy R. Howe, Boston, Mass.
Interpretation of Pains About the Head. Frederick B. Moorehead, Chicago, Ill.

Some Common Diseases of the Oral Mucous Membrane and the Tongue. Hermann Prinz, Philadelphia, Pa.

Rehabilitation of the Mouth with Gold. Arthur G. Smith, Peoria, Ill.

RESEARCH COMMISSION REPORT.

Cure of Focal Infections. M. L. Rhein, New York, N. Y.

Removable Bridgework, Showing Some New Devices and New Arrangements of Old Devices. Charles F. Ash, New York, N. Y.

Indications for and Limitations of Alveolectomy. Victor H. Sears, New York, N. Y.

Indications for and Limitations of Apicoectomy. Adolph Berger, New York, N. Y.

Correction of Maxillary and Palatal Defects Preparatory to Prosthetic Restoration. Harold S. Vaughan, New York, N. Y.

Prosthetic Restoration After Surgical Treatment, War-Time Work (Lantern Slides). Joseph D. Eby, New York, N. Y.

Prosthetic Restoration After Surgical Treatment, Peace-Time Work (Lantern Slides). Edward Kennedy, New York, N. Y.

There will be an Oral Health Dinner at the Hotel Astor during the meeting of the Society. It is expected that there will be many very attractive features in connection with this dinner. Prominent public officials are expected to be present and the addresses and demonstrations will be of the very highest order.

During the time of the meeting of the New York State Dental Society, sessions of the New York State Dental Hygienists Association and the Dental Assistants Association will be held.

Every effort is being put forth to make this meeting one of the most attractive in the history of the Society. Reduced railroad rates have been secured.

A cordial invitation is extended to all ethical practitioners. Admission to the literary meetings and clinics may be secured by registering and presenting membership cards in the State or National Societies. Headquarters will be at the Hotel Astor, and reservations should be made direct with the hotel management. For further information and programs, address A. P. Burkhart, Secretary, 57 East Genesee Street, Auburn, N. Y.

February Meeting

OF THE

PATHODONTIA SECTION, FIRST DISTRICT DENTAL SOCIETY, NEW YORK

At the February meeting of the Pathodontia Section of the First District Dental Society, New York, the essayist, Emilie C. Schirmer, M.D., of Brooklyn, had for her subject *Some Practical Experiences with Dental Focal Infection*.

To avoid confusion, Dr. Schirmer decided to omit all scientific consideration of her subject and give the results observed in her laboratory work for dentists and physicians.

"A dentist sees the teeth only," said Dr. Schirmer. "He rarely obtains a complete history, nor does he follow the case and see the final

results. Pain and other symptoms may be due to infected tonsils, reflex pain, psychosis or intestinal intoxication. The x-ray is a valuable aid in diagnosis but is not always dependable. A blood and urine analysis may be helpful, the blood showing a relative lymphocytosis, the urine containing streptococci which are foreign to normal urine. These are conditions found in dental focal infections. Dental focal infections may cause muscular pain, as lumbago, joint pains in knee, ankle or shoulder, valvular heart disease, neuritis, general fatigue and lack of ambition."

Dr. Schirmer proceeded to describe infection as a successful invasion and growth of microorganism in the tissues of the body, and immunity as effective resistance to bacterial invasion, adding that this may be acquired or passive. She stated that the streptococci at the root ends of teeth multiply and produce powerful poison, which is distributed throughout the body.

Continuing, Dr. Schirmer said: "The cocci may leave their habitat and settle at some distant point such as the heart, kidneys, stomach, producing lesions. A microorganism may be associated with a certain organ and do no harm until special conditions arise, when it rapidly invades tissues and causes infection. This is illustrated by the constant presence of staphylococci and streptococci in the tissues of most persons, usually harmless but under special conditions capable of producing severe and even fatal infections."

Dr. Schirmer has followed up a number of cases after extraction of teeth and observed the results and cited these histories to supplement and corroborate her remarks.

Charles G. Darlington, M.D., Professor of Pathology, School of Dentistry, New York University, opened the discussion. He agreed with the essayist in part, stating that there is no doubt that infected teeth are the seat of primary lesions in certain systemic diseases, but that it is extremely difficult to make a diagnosis with the teeth as a definite seat of focal infection. Other factors to be considered are tonsils, sinuses, nose, bronchi, gall bladder, biliary tract and genito-urinary tract.

In concluding his remarks, Dr. Darlington stated that investigative work of this type should be encouraged.

H. J. Kauffer, D.D.S., in discussing Dr. Schirmer's paper, stated that a lymphocytosis or the presence of streptococci in the urine is the same as all other systemic tests and does not identify infection with any particular location in the human anatomy. A secondary infection will always give the same systemic reaction as will a primary focus, Dr. Kauffer claimed. "Therefore," said he, "I will not accept any systemic test in consideration of a periapical infection and its relation to focal infection."

DENTAL LAWS

Summary of Dental License Requirements Throughout the World

By Alphonso Irwin, D.D.S., Camden, N. J.

RHODE ISLAND (RECIPROCITY)

The State of Rhode Island presents the attitude of Non-Reciprocating Boards of Dental Examiners towards reciprocity so fairly that we quote it as typical for the United States of America.

"The attitude of the Rhode Island Board towards reciprocity rests entirely within the discretion of the Board. There is no reciprocity between Rhode Island and any other state. However, if a man is of good standing professionally and morally in the state from which he comes, if he is a member of the State Dental Society and has walked the straight and narrow professional path, the Board extends to this candidate leniency and uses its discretionary powers with the result that no man meeting the requirements alluded to above is ever turned down. This, in the view of Rhode Island State Board of Registration in Dentistry, is practical reciprocity."

Verified July 12, 1924, by A. L. Midgely, Secretary.

RHODESIA (NORTHERN)

TRANSCRIPT—PROCLAMATION—No. 11, 1920

4. The following persons may be admitted by the Administrator to practise in the territory as dentists:

(1) Every person having before the commencement of this proclamation obtained a license to practise as a dentist in the territory, unless after due inquiry by such officer as the Administrator may appoint, he shall be deemed by the Administrator to have obtained such license by any false or fraudulent representation or declaration.

(2) Every person admitted and lawfully entitled to practise as a dentist in the Union of South Africa or in Southern Rhodesia.

(3) Every person who is a licentiate in dental surgery or dentistry in the United Kingdom or in any British Colony or Possession.

(4) Every person proving to the satisfaction of the Administrator that he is a holder of a certificate, diploma or other sufficient document entitling him as the holder thereof to practise dentistry or dental surgery in any foreign country and furnishing sufficient evidence of the possession of the requisite knowledge and skill for the efficient practice of dentistry or dental surgery: provided, that persons applying under 2, 3, and 4, shall have undergone a curriculum of three years at least.

(5) Any person desirous of being admitted to practice as a medical practitioner or dentist in the territory shall make written application to the Administrator.

The application must be accompanied by the original documents (diplomas, certificate, etc.) under which the applicant claims to be qualified for admission, together with the following declarations sworn before a Justice of the Peace: (1) Of personal identity; (2) Of the authenticity and present validity of the aforementioned documents; (3) If applying for admission to practise as a dentist of the fact that the applicant possesses one or other of the qualifications mentioned in section 4 hereof.

Section 6. It shall be lawful for the Administrator, in his discretion, to refuse to admit any person to practise dentistry under this Proclamation.

7. (a) Every person admitted to practise as aforementioned shall be registered in a book to be called the "Register of Medical and Dental Practitioners," hereinafter called the "Register," kept by an officer appointed by the Administrator, in which shall be entered all the names, addresses, qualifications and dates of registration of all medical practitioners and dentists admitted to practise under this Proclamation.

(b) A fee of five pounds shall be charged upon each registration except in the case of a person who, prior to the taking effect of this Proclamation, had obtained a license to practise as a medical practitioner or dentist in the territory.

Verified March 20th, 1925, by Buxton High Commissioner, and H. J. Stanley, Imperial Secretary.

RHODESIA (SOUTHERN)

Applications for admission to practise as a dentist in Southern Rhodesia should, in the first instance, be addressed to the Secretary, Department of the Colonial Secretary, Salisbury, Southern Rhodesia, and the application should be accompanied by the original diploma, to-

gether with a sworn declaration of identity. The registration fee is £5, and this sum should accompany the application.

Persons who are registered to practise in the United Kingdom may submit their British Dental Registration Certificate in lieu of the original diploma.

Dentists registered to practise in England under the provisions of the Dentists Act of 1921 are not eligible for registration in Southern Rhodesia.

In regard to applications for registration from dentists possessing American diplomas it would be helpful and possibly save delay if at the time of application the applicant would also furnish a sworn affidavit from the Principal of the Faculty which granted his Diploma to the effect that the Diploma submitted actually covered a curriculum of at least three years, the term "curriculum" being defined in Section 2 of Ordinance 8 of 1913, namely, "Curriculum shall be the course of study necessary to a student before he can present himself for examination as a candidate for a diploma, license or other certificate before the examining body of any university, college, or other qualifying body."

Verified March 28, 1925.

SYNOPSIS OF DENTAL LICENSE REQUIREMENTS FOR SOUTHERN
RHODESIA, SOUTH AFRICA, DATED 1900, AMENDED 1913

English language, Medical Council supervision and registration of dentists are required. The Ordinance states: 1. The persons following shall be admissible to practise as dentists in Southern Rhodesia and to obtain the requisite license so to practise.

(1) Every person duly admitted and lawfully entitled to practise in the Colony of the Cape of Good Hope as a Dentist.

(2) Every person who is a licentiate in Dental Surgery or Dentistry in the United Kingdom (of Great Britain), or in any British Colony or Possession.

(3) Every person who shows to the satisfaction of the Administrator that he is the holder of a certificate, diploma or other sufficient document, entitling him as the holder thereof, to practise dentistry or dental surgery in any foreign country, and furnishing sufficient evidence of the possession of the requisite knowledge and skill for the efficient practise of Dentistry or Dental Surgery.

(4) All Dental diplomas registrable in Southern Rhodesia shall be required to cover a minimum curriculum of three years.

(5) Every person, who before the passing of this Ordinance obtained admission or authority to practise as a dentist in Southern Rhodesia.

Registration fee £10 (about \$50.00 U. S. C.) payable to the Secretary of the Medical Board; Annual Tax £5 payable to Receiver of Revenue. Address for further details the Medical Director.

Medical Director's Office,
Salisbury, Rhodesia.

SPECIAL AMENDMENT

By and with the advice and consent of the Legislature of the Colony of Southern Rhodesia, as follows:

1. Notwithstanding the provisions of "The Dentistry Ordinance 1900," as amended by the Dentistry Amendment Ordinance, 1913 (hereinafter referred to as "the said Ordinances"), the extraction of teeth by unlicensed persons in rural areas and in towns or villages, where no registered dentist is resident shall not be deemed a contravention of the practice of dentistry as defined by the said Ordinances, but such extraction of the teeth shall not constitute a claim for registration as a dentist under the provisions of the said Ordinances."

PENALTY

2. Any unlicensed person authorized to undertake the extraction of teeth in terms of the last preceding section, advertising or travelling in furtherance of such undertaking shall be guilty of an offense and liable on conviction to a fine not exceeding £25 and in default of payment to imprisonment with or without hard labour for a period not exceeding one month.

3. This Act may be cited for all purposes as the "Dentistry Ordinances, Short Title Amendment Act, 1924."

RIO DE JANEIRO (BRAZIL)

There is a large field for dentists in Rio de Janeiro, and it is generally considered a very remunerative profession. In order to practise dentistry here it is necessary to pass an examination without the aid of an interpreter. The examination is given in the Portuguese language. However, several American dentists have apprenticed themselves to other American dentists until such a time as they could pass the required examination.

Verified June 26th, 1923 and 1925.

Rio de Janeiro, Brazil, does not interchange dental licenses. The States of Brazil contain many dental colleges. The City of Rio de Janeiro alone has three dental colleges. Alien dentists desiring to practise their profession legally in Rio must spend one or more years in a dental college of Brazil graded according to the year's examination in such college's prescribed course, which they may be able to

pass successfully. Said examinations are the same as those required of native students pursuing the dental course of study.

At least one year must be devoted to the attendance of the dental course in this college, whatever may be the qualifications of the candidate acquired in the educational institutions of a foreign country.

Address Escola Livre de Odontologia Do Rio de Janeiro, Rua Carioca 55, Rio de Janeiro, Brazil, S. A.

All communications should be written in the Portuguese language.

REGULATIONS GOVERNING THE PRACTICE OF DENTISTRY

Graduate from foreign schools of dentistry, must obtain a certificate of qualification from an official or recognized school of the country. The requirements for obtaining this certificate are set forth in Decree No. 11,530 of March 18, 1915, reorganizing the Secondary and Superior instruction of the Republic.

a. The candidate must exhibit his diploma, which must be vised by a Brazilian Consular officer in the foreign country. The Brazilian consular officer requires the vise of the Secretary of State of the United States, which in turn requires that the signatures be acknowledged by the Secretary of State of the respective State where the college is located. The vise of the Brazilian consular officer is acknowledged in Brazil by the minister of foreign relations, after which it is submitted to the school authorities.

b. The payment of the special examination fee.

c. Pass the examination of the subjects of the course, the examination to be held in Portuguese without the aid of an interpreter.

Art. 54. Candidates for admission to the course of dentistry must comply with the formalities prescribed in Articles 3, 4 and 5 of the present regulations.

Art. 3. Candidates must present the following documents: (a) A certificate showing the candidate to be at least 16 years of age; (b) A certificate of moral character; (c) A certificate showing that he has passed the entrance examinations; (d) A receipt of payment of matriculation tax.

Art. 55. The branches required in the course of dentistry are the following: Descriptive Anatomy (particularly of the head); Microscopic Anatomy; Dental Physiology, general Pathology and Pathological Anatomy; Course in dental technique (practise on dummy); Dental Clinic, Dental Therapeutics; Dental Prosthesis; General Hygiene, particularly of the mouth.

See Brazil for other information.

RIO DE ORO

This Spanish Protectorate on the northwest coast of Africa would

come under the colonial dental license regulations of Spain, if any professional license requirements are enforced, which is doubtful. No recent official information in regard to the practice of dentistry is available for obvious reasons, from this region.

RIO GRANDE DO NORTE (BRAZIL)

See Brazil for the Dental License Requirements in Rio Grande do Norte; also Rio de Janeiro.

RIO GRANDE DO SUL (BRAZIL)

See Brazil for the Dental License Requirements in this, one of the most populous and important States of Brazil with its capital of the same name, rating as the third city of the State. Consult also Rio de Janeiro regulations for the practice of dentistry.

RIO MUNI

No recent official report of the dental license requirements have been received from this Spanish protectorate located on the west coast of Africa. The colonial dental laws of Spain, if any, are enforceable. The population consists of Africans. There are few white.



DENTAL ECONOMICS

Was It a Special Deposit?

By M. L. Hayward, Hartland, N. B., Canada

"I have taken the agency for the Inland Finance Corporation, and they want me to put up the usual \$1,000 bond. Will you sign it?" the patient asked.

The patient was one of the dentist's best, but the latter naturally demurred.

"Why don't you get the usual bond from a surety company?" he suggested.

"Oh, you need not be afraid," the patient assured him. "I'll deposit \$1,000 cash with you, you can deposit the cash in the bank in your own name, hold it as long as the bond runs, and credit me with the bank interest."

"I don't see how I'm running any risk that way," the dentist agreed, signed the bond, accepted the cash, and deposited it in the local bank, after explaining the circumstances to the cashier.

"We can arrange that easily," the cashier told him, and handed the dentist a deposit slip marked "escrow account," and the deposit slip stated at the bottom that the money had been deposited in escrow as a surety on a certain bond, "to be used only in case of forfeiture of the bond."

A month later the bank was insolvent, and the State Finance Commission took charge.

"I didn't have enough to my credit to worry about," the dentist assured himself, and demanded the \$1,000 deposit in full from the Commission.

"You've got to take 'pot luck' with the general creditors of the bank," the Commission told him.

"No, this was a special deposit. I'm entitled to be paid as a preferred creditor ahead of the general creditors," the dentist contended, and the Missouri Court of Appeals ruled in his favor in a case reported in 253 S. W. 15.

"Under these facts the trial court was clearly justified in holding

that this was not a general deposit, but was held as a special deposit, the title to which did not go to the bank, but on the other hand it was acting as a mere trustee or bailee of this fund, to be paid out to the dentist in the event that he suffered loss on account of having signed the bond, and to be checked out by him and paid back to the customer in case he was not required to pay anything by reason of having signed the bond," said the Court.



PRACTICAL HINTS

This department is in charge of V. C. Smedley, D.D.S., and George R. Warner, M.D., D.D.S., 610 California Building, Denver, Colorado. To avoid unnecessary delay, Hints, Questions and Answers should be sent direct to them.

NOTE—Mention of proprietary articles by name in the text pages of the DENTAL DIGEST is contrary to the policy of the magazine. Contribution containing names of proprietary articles will be altered in accordance with this rule. This Department is conducted for readers of the DENTAL DIGEST, and the Editor has no time to answer communications "not for publication." Please enclose stamp if you desire a reply by letter.

Editor Practical Hints:

I have a lady patient, thirty-six years old, who complains that she has a constant flow of saliva in her mouth, and it has a sweet taste. I have tried everything I know to stop it—alum water, atropin, etc., with no results. I would appreciate it if you could advise me what to do to stop it.

T. W. S.

ANSWER.—An excessive flow of saliva is due, of course, to stimulation of the salivary glands. Aside from the stimulation of hunger, savory food, food odors, and masticating, which are normal stimulants, we have the stimulation caused by physical conditions, such as local poisoning from infection or chemicals, and the irritation from ragged teeth or dentures. Of general chemical poisoning mercury is one of the most common, so you should determine if the patient is taking mercury in any form. Then all possible systemic discrasia should be considered. Diabetes mellitus might be responsible in part for the excessive flow, and particularly for the sweet taste.

It would seem, therefore, that the rational course of action would be to free the mouth from infection and mechanical irritants and then turn the patient over to a physician for a general physical examination to see if he can discover any further cause for the ptyalism.—G. R. WARNER.

Editor Practical Hints:

I have a patient who has all the molar and bicuspid teeth on his right side out. There are no other teeth missing on his upper jaw. I made an appliance consisting of a cast gold palatal bar, a clasp on the right cuspid and a clasp on the left first molar. I had to grind

the molar down in order to get the clasp on. I made a rubber saddle holding the molar and bicuspid teeth. When he bites, the saddle tips so that the clasp on the molar rides up and down. I have rebased the saddle, but still the "give" on the gum tissue causes the appliance to rock.

Would you give me some information as to what to do in this case? I thought probably if I extracted a tooth on the left side and put in a small saddle there and two clasps, that the appliance would hold.

W. C. M.

ANSWER.—It is evident from the description of your case that it is out of balance, and it is probable that no amount of re-basing the saddle will overcome the difficulty. I would suggest the advisability of changing the plan of construction in this way: If the third molar is missing on the left side make a disto-buccal lingual clasp on the second molar; if it is possible to do this set the clasp or crib over the first molar very securely then extend a rest forward from the palatal bar to the lingual surface of the left cuspid. If in addition to this attachment and rest on the left side you have a good mesio-distal clasp on the right cuspid the case should give reasonably good service if the occlusion is properly adjusted. It probably would be of no advantage to extract a tooth on the left side and put in a small saddle.—G. R. WARNER.

Editor Practical Hints:

Will you kindly give me some information regarding the following questions?

(A) There are some teeth, mainly upper lateral incisors—according to my observations—which being normal, as far as clinical evidence is concerned, show a tendency to outgrow or be dislodged from their sockets. I don't know and have been unable to find an explanation, and when examining these cases, discarding pericemental disturbances, i.e., inflammation, exudative or suppurative, traumatic or lack of occlusion, soft and hard deposits (the latter corroborated by extraction), or any other factor, I feel very uneasy, expecting the patient's question about the cause of the trouble.

(B) Do all teeth have a tendency to elongate in their sockets? If not, why do they—especially the posteriors—elongate after removal of their antagonist?

(C) We are instructed by authorities in periodontology to grind the teeth affected by traumatic occlusion, and in severe cases to keep them from occluding at all. After a short time these teeth elongate and again come in contact with the antagonist. Should we keep on grinding?

P. C.

ANSWER.—Answering your questions under the various headings, would say under (A) that the observations of men of wide experience whom I have consulted are in accord with my own observations, that maxillary lateral incisors do not tend to extrude from their sockets when they are normal. I think you will find, if you check back closely, that those which have extruded from their sockets are usually labial to the normal contour of the arch, and that frequently they overlap the central incisors. In other words, there is a lack of occlusion. To be sure, the lateral incisors of the maxilla have the poorest blood supply of any teeth in the mouth and the labial alveolar plate is thinner than over the adjoining teeth; so, for these purely anatomical and physiological reasons, they would be more apt to elongate than some of the other teeth in the mouth.

(B) All teeth have a tendency to elongate in their sockets if they are not functioning.

(C) The instructions from periodontologists in relation to grinding teeth affected by traumatic occlusion have been misunderstood by very many practitioners. The grinding of teeth in traumatic occlusion is intended to alter the shape of the teeth but not to shorten them, except in those instances where the teeth have elongated so that it is impossible to give them rest without shortening them, but even in these cases they should be so shaped in grinding that when they do come down to occlusion again they will not suffer from traumatism. I say this knowing full well that it is sometimes necessary to grind teeth several times before the disease processes of the periodontal membrane have been entirely overcome.—G. R. WARNER.

Editor Practical Hints:

Could you answer the following questions for me?

How to bring the gums back to their normal position around the neck of the tooth after it has receded, exposing part of the root, in the case of an individual tooth, or several teeth?

Also, what pre- and post-extraction steps to take for a patient who tells me he shows a tendency to persistent bleeding after extraction?

A. F.

ANSWER.—There is no way known to dental science to bring gums back to their normal position around the neck of a tooth after it is receded. The recession is simply ocular evidence of the destruction of this portion of the periodontium which supports the marginal gingiva and with the support of the gum gone it cannot build down again to its original position.

If one has a known or suspected hemophiliac, one may determine by a very simple method the clotting time of the blood. Prick the

ear with a fine needle, press out a drop of blood. If it clots within four minutes there is no danger of bleeding; if it takes longer than this the danger increases in ratio to the length of time. If there is a strong tendency to bleed, treatment should be started three days before the extraction. The patient should be given ten grains of calcium lactate three times daily and one injection of 4cc of a suitable coagulant each day. If the blood clots at four minutes or shortly after, treatment for one day before the extraction will be sufficient. Following the operation one more injection of the coagulant should be given and the calcium lactate administered for one or two days.—G. R. WARNER.

Editor Practical Hints:

Kindly advise the best method of diagnosing Vincent's Angina and the best treatment. As there are about as many treatments as there are ideas concerning diagnosis, would appreciate your advice concerning same. Having picked up some very useful hints from the DIGEST, thought you might be able to help me in this matter.

F. X. T.

ANSWER.—Vincent's Angina is characterized objectively by high inflammation of the marginal gingiva which changes within a day or two to a gray slough of the marginal gingiva with a fetid, disagreeable odor of the breath. Subjectively the patient experiences much pain and extreme soreness of the gingival tissues. This condition is usually accompanied by a rise in temperature, often two or three degrees. The final diagnosis is made by the microscopical examination of the exudate from beneath the margins of the gums.—G. R. WARNER.

Editor Practical Hints:

I have a case in which the incisal edge of the four lower incisors are worn down so far that the teeth are quite sensitive at times.

Would you advise the silver nitrate treatment, and if so, how can you remove the dark stain left after treatment?

I prefer not to crown the teeth if they can be treated successfully otherwise.

Your advice will be appreciated.

F.B.

ANSWER.—It is not possible to advise you as to the best course of treatment in your case without seeing it. The silver nitrate treatment is the most efficient in desensitizing occlusal or incisal areas in teeth, but it is difficult, if not impossible, to remove the stain. I would suggest that in the event you wish to protect the sensitive areas that it is not necessary to crown the teeth, you can do it with inlays, in which case, of course, it would be necessary to use them on all of the lower teeth so that the occlusion would be balanced.—G. R. WARNER.

Editor Practical Hints:

I am asking for information. Is there any remedy, where a red rubber plate causes burning and inflammation of the mouth—any drugs or wash—outside of making a metal plate? Or, if you can tell me where to find that information I will be greatly obliged.

F. E. H.

ANSWER.—I do not believe there is any drug or wash that would satisfactorily or at all permanently relieve this condition.

It would be best to make a metal plate, but very likely the condition would clear up under a rubber plate made of black or natural base rubber, as the pigmentation in red or any colored rubber is supposed to be the principal cause of rubber sore mouth.—V. C. SMEDLEY.

Editor Practical Hints:

Patient 33 years old. Nervous, and not a very strong heart. Removed all his teeth on account of the pus conditions.

Have given two mandibular injections at different times and with this result: Perfect action on tongue and lip and two posterior teeth, but not the rest. I removed these two and the next two became affected by the anesthetic, and so on around until all teeth on that side have been removed. I am using a good anesthetic, but why does this not affect the whole side?

H. C. G.

ANSWER.—I wonder how you arrived at the conclusion that the two posterior teeth only were fully anesthetized, and what made you think that the next two were anesthetized after extracting the last two? What I am getting at is this: Did you test the buccal surface of the gum to determine whether the area was anesthetized? If you did it is possible that you did not have an anesthesia of the long buccal nerve but that from the trauma of extracting the two last molars this nerve became anesthetized. With a good anesthesia of the tongue and lip you certainly had an anesthesia of the inferior dental nerve, and having an anesthesia of the inferior dental nerve I can't see why you didn't have an anesthesia of the cuspid, bicuspid and first molar in the first place. You might not have had a complete anesthesia of the incisors, because some fibers cross over from the opposite side of the mouth. I can think of no other reason for your not having had a positive response to the test than that noted above, i. e., failure to anesthetize the long buccal nerve.—G. R. WARNER.



DENTAL SECRETARIES and ASSISTANTS

Secretaries' Questionnaire

All questions and communications should be addressed to Elsie Pierce, care of THE DENTAL DIGEST, 220 West 42nd Street, New York City.

NOTE—HAVE YOU A BETTER WAY? HAVE YOU A TIME-SAVING SHORT CUT? DO YOU KNOW A "STUNT" THAT LIGHTENS THE WORK OR MAKES FOR EFFICIENCY IN THE OFFICE? IF SO, WRITE TO ELSIE PIERCE, CARE THE DENTAL DIGEST, 220 WEST 42ND ST., NEW YORK. YOU MAY HELP A NUMBER OF GIRLS WHO ARE JUST BEGINNERS—AND YOU KNOW HOW YOU NEEDED HELP DURING YOUR FIRST FEW MONTHS IN A DENTAL OFFICE. OR IF YOU NEED HELP NOW WRITE TO ELSIE PIERCE—SHE'LL HELP YOU.

I am to graduate from high school in June and have been offered a position in a dental office as chair assistant. Will you be kind enough to tell me what are the duties expected of me in filling this position?

A. H., Pittsburgh, Pa.

Your question is brief and to the point, but to answer in detail would require pages. However, I will endeavor to touch upon the principal requirements. First of all, you must understand that each dentist has his own particular technic in operative procedure, therefore set rules or methods are not possible. Yet to one with a background of high school training and mentally alert, with a desire to spare no effort in learning the service required, chair assisting should be mastered in a comparatively short time.

In general, I may say that you should be sure to have the operating chair in proper order, the bracket table aseptically clean, the cuspidor spotless and the linen clean and fresh. As the patient sits in the chair, the chair assistant should place a clean cover on the headrest and adjust it to the patient's comfort. Then the napkin, bib or apron should be placed about the neck of the patient, the drinking paper cup or glass should then be taken from the glass cabinet and placed, filled with warm water, in front of the patient (cold water is extremely unpleasant

to sensitive teeth). This warm water should be poured from a brightly polished glass pitcher, which is at all times kept covered with a clean napkin. Then place a tray on the bracket table containing such instruments and material as the doctor may require for each operation, being sure that they have been carefully sterilized. Different operations require different instruments with which you will have to familiarize yourself, but if you pay strict attention to the doctor's manner of operating, you will quickly learn what is needed for each patient. In relation to this, if you will study the day's outline of appointments and what is to be done for each patient, you can more easily get ready what is needed for each case.

The chair assistant is usually required to mix cements, amalgams, synthetic porcelains, etc., and prepare wax, plaster or compound for impressions. No beginner would understand directions about this procedure without practical teaching, and it is reasonable to suppose that the doctor by whom you are employed will be willing to give you this instruction.

The sterilizing of instruments, linen and surgical supplies is a part of the work of a chair assistant, and the technic is simple and easy to learn. The operating room will be your special charge, and its orderliness and neatness your responsibility. In some offices the chair assistant assists the doctor with the developing and mounting of x-rays, which is not difficult to learn.

When the patient is dismissed, all instruments should be promptly removed from the bracket table and placed in the sterilizer. All soiled linen should be removed from about the chair, and everything quickly put in order for the next patient. There is nothing so distressing to nervous and sensitive patients as to see traces of the previous operation in evidence when they take the chair.

Again let me say that the duties of a chair assistant vary so widely that each office is a problem unto itself. Some dentists require their assistant to stand at the chair every moment of the time; others do not want their assistant standing at their elbow. The most important suggestion I can give you is to pay strict attention to your work, to the instructions given you, and, above all things, not to make it necessary for the doctor to have to repeat his directions constantly. Added to this, the exercise of tact and cheerfulness at all times will greatly help to fulfill your duties.

I have been employed as a dental assistant only a few months. My employer is very patient and tries to teach me all he can and I am learning very fast, but many times I am very much discouraged, as there is so much I could do if I only knew more about what is required of a capable dental assistant.

My greatest difficulty seems to be with the patients. I get very nervous when I have to speak to them, either personally or on the telephone. I never know just what to say, I am afraid I do not talk to them as much as I should, and it is hard for me to know just how to greet them or dismiss them. Please tell me what I can do to become more at ease. I am greatly interested in my work and want to be a good dental assistant, so that I can really help the doctor and his patients.

"I have been reading your department faithfully and all about the societies for dental assistants. I wish I might attend some of their meetings, but unfortunately there is no such society in this locality. I shall greatly appreciate hearing from you.

M. S., Missouri.

No doubt there are many young women who accept a position in a dental office and find themselves afflicted with the same degree of uncertainty that you seem to be experiencing. The duties in a dental office are highly technical, and it is not to be supposed that anyone without experience can at once grasp all the details of the service expected. You are fortunate in being employed by a dentist who is willing and has the time to teach you the details of your duties. Close observation and strict attention to the work in hand will enable you to anticipate what is required for each operation and thus you will acquire capability. You may add to your knowledge by a careful reading of the dental literature to which you may have access and the dental magazines that come to your office.

Many young people have difficulty in meeting strangers. This is due to too much self-consciousness and lack of confidence, but can be largely overcome in your case if you will but remember that the people who come to a dental office are no different from those you meet anywhere else. Conversations with patients should be confined strictly to professional matters; extended conversations of a personal nature are entirely out of place. A certain amount of affability and tact in greeting patients and dismissing them is all that is required, and in this you will please both the doctor and his patients.

In using the telephone speak in a clear, distinct voice, not too fast or too loud, paying strict attention to what the person at the other end is saying. Do not speak for the doctor without his direction, and if the call is for an appointment, always consult your appointment book so that you will not give a patient an hour that is already taken. Here, too, tact and a pleasant voice are essential. Conversations over the telephone are no different from personal ones and should be carried on in the same manner.

I would suggest that you join a class in public speaking—not that

you wish to become a public orator, but I know of nothing that will give you more poise, confidence and the ability to express yourself with ease. Such classes are usually given by the Y.W.C.A. and many women's clubs. Every society for dental assistants should have this instruction as a part of its educational program, and I believe that most of them do. As far as I know, they are providing education and training not found elsewhere.

February Meeting

OF THE

EDUCATIONAL AND EFFICIENCY SOCIETY FOR DENTAL ASSISTANTS,
FIRST DISTRICT, NEW YORK, INC.

At the regular meeting of the Educational and Efficiency Society for Dental Assistants, First District, New York, which took place at the Academy of Medicine, 17 West 43d Street, New York City, on February 9, 1926, the speakers of the evening were Warren Hall, M.D., Ph.D., and Samuel G. Mischlin, D.D.S. Dr. Hall spoke to the topic *Dynamic Force*, giving a very interesting, though necessarily brief, lecture on practical psychology. *What Is the Aim of Human Life and Is There a Philosophic Reason to Prolong It?* was the title of the paper presented by Dr. Mischlin. The speaker stated the belief that happiness is the aim of human life and described the gallant battle that modern science, with particular reference to oral surgery, is waging against disease, thus helping to further the happiness of mankind. The program was enthusiastically received by the audience.

Emily Campbell, Director of Classes, reported the success of the classes in X-Ray Technic and First Aid, which have just been brought to a close, and announced the formation of a class in Model-Pouring Technic. The class in Public Speaking and Parliamentary Procedure has already begun its work, meeting on each Thursday evening at 7.30 at the office of Dr. Henry Fowler, 174 West 96th Street, New York. It is the aim of this class to afford the members practice in parliamentary procedure and to gain for them poise, resourcefulness and the ability to express their opinions in a clear, logical fashion. All classes conducted by the Society are under the direction of members of the dental profession and are so arranged that they do not conflict, giving the young women the opportunity to attend more than one at a time, and do not interfere in any way with the routine duties of the assistant. The sessions are held usually on one evening of each week.

It was announced that the annual dinner of the Society would be held on Wednesday evening, May 19, 1926, at the Hotel Astor, New York, and that the officers of the Dental Society of the State of New York would be among the guests. Maude Sharpe is Chairman of the Dinner Committee and may be reached at 8 West 40th Street, New York City.

The meetings of the Society are regularly held on the second Tuesday evening of each month, October to May, inclusive, at the Academy of Medicine, New York City. A welcome is extended to the members of the dental profession, and dental assistants are also cordially invited.

Important Notice

The second annual meeting of the AMERICAN DENTAL ASSISTANTS ASSOCIATION will be held at Philadelphia, Pa., August 19-21, 1926. Plans are being perfected for a very interesting and enjoyable meeting. Prominent members of the dental profession will address the various sessions. Clinics and papers will be given by the members of the Association and there will be an annual luncheon with prominent guests and an interesting program. Time and place will be announced at a later date.

All dental assistants are urged to plan their vacation so as to visit Philadelphia at that time and attend the meeting.

ANNA H. SYKORA, General Secretary,
8 West 40th Street, New York, N. Y.

Educational and Efficiency Clinic Club

The program of the regular meeting of the Educational and Efficiency Clinic Club held on February 15, 1926, at the office of Dr. W. H. Hynard, 40 East 41st Street, New York, deviated slightly from the usual procedure. The Club is composed of several sections, each one individually representing a different phase of dental assisting and the whole being an exposition of the routine work of one dental assistant. It is the usual custom at the regular meetings to present a table clinic explaining one aspect of dental assisting. Thus is one evening devoted to secretarial assistance, another to chair assistance, etc., until the several sections have been demonstrated. It is by this means that the members strive to increase their knowledge of their duties and their search for more efficient methods of procedure in their work.

At the February meeting, however, the sections were presented in lecture form. Anna Sykora spoke on *Secretarial Assistance*; Sylvia Danenbaum on *Chair Assistance*; Jean Tallaksen on *Gold Inlay Casting*; May Bennett on *Orthodontic Assistance*; and Emily Campbell on *X-Ray Assistance*. A general discussion followed in which the points brought out by the speakers were analyzed and many new suggestions and ideas added. At the next meeting the Sterilization and General Laboratory Sections will be reviewed in a similar manner.

The Clinic Club meets regularly on the third Monday of each month, October to May, inclusive. A cordial invitation is extended to the members of the Educational and Efficiency Society for Dental Assistants, New York, and they are urged to join in its activities.

Leaves from the Notebook of Janet Cross, a Dental Assistant

January 10, 1926. *Dear Diary* (as they say in *The Saturday Evening Post*—although you are not really a diary, but just a notebook in which I am recording the high spots and landmarks in my life as a dental assistant):

Last December closed my first five years in dentistry as an assistant, and with the first of this month the second half of my first decade has begun. When I look back at all the mistakes of those five years, I blush for shame, and when I think of the many useful services that I have rendered, consciously or inadvertently, I blush with modest pride! My opportunities have been many—I can realize them all, now that they are past—but I do believe that I have grasped a good percentage of them and have done well by my job. However, I hereby resolve that the next five years shall show a still greater steadfastness of purpose, a still broader vision and a finer record of achievement.

And when I write this, I believe, Notebook, that I am writing it for all dental assistants. It is just about during the last five years that dental assisting has made its greatest strides. Of course there has been some sort of assistant in dentistry for many years, but her efficiency and service have never been up to what they are today. True, there are exceptions—such as the older members of our assistants' societies, who have been assisting for from fifteen to twenty-five years and who are the real pioneers of the dental assisting of the present—but, as a general rule, in the past the young woman in the dental office has served more in the capacity of maid and office girl than as the second right hand and supplementary brain of the dentist, as she is today. This

change has come about slowly, to be sure, with the assistant learning as she worked, but only a few years more will doubtless see the standardization of the training of the dental assistant, courses established in colleges, and what is now a calling transformed into a profession. That's what every right-minded dental assistant is working toward now, and it will be a magnificent thing for dentistry and the laity, as well as for the young women concerned, when it comes! It will mean dignified, respected work for women, with almost unlimited opportunity for real service to humankind; added dignity to the dental office; trained, competent help for the dentist, saving time and energy that he can apply to study and research; all aiding dentistry to advance, to build and to maintain finer standards of service to the patients.

January 12th. What a splendid meeting we had at the Academy of Medicine tonight! I have been attending the meetings of the Educational and Efficiency Society for Dental Assistants, New York, each month for the past four years, and there have been many notable ones—the night when Dr. Dunning came to speak to us on *Asepsis in the Dental Office*; when Dr. Tracy spoke on *The Assistant in the Dental Office*; when Elizabeth Sears and Katherine Devereux Blake, prominent clubwomen, addressed us; when Dr. Waugh spoke on the *Greeting of Service*, and again last month on *Ethics*; when Dr. Boyd S. Gardner spoke on *The Necessity of the Trained Dental Assistant in the Practice of Dental Surgery*; Mrs. Angelique Orr told of some of *The Advantages of Parliamentary Procedure*; and when Drs. Gillett, Vetter and McCall addressed the Society. What a story the past programs tell! Then the meetings when we members stood on the platform ourselves and “essayed”! Du Bois Hall holds many happy memories of evenings pleasantly and profitably spent, and no doubt it will serve as the home of equally fine meetings in the future.

To-night, Notebook, the President of the Dental Society of the State of New York, Dr. R. Ottolengui, spoke on *Efficiency*, affording us a most enjoyable hour. He has such a delightful sense of humor and ready wit! In his more serious moments he placed special emphasis on the qualities of preparedness, forethought and intuition in the make-up of the dental assistant. He also invited us, as a society of dental assistants, to conduct the course in Office Management which the State Society is giving in its series of postgraduate studies during its annual convention at Hotel Astor this coming May. In accepting the invitation for the Society, Miss MacNeil stated that the girls are always willing to serve and aid dentistry and the dental profession in this way, but that we have difficulty in getting away from the office. And very true it is! But, Notebook, if the girls will only make the dentists understand that the purpose behind our clinics is to promote greater efficiency in the dental assistant and that everything we do, both in

our offices and in our society work, is for the ultimate good of dentistry and to help to further its progress, I am certain that there would be very little objection to allowing the assistants a few free hours on an afternoon once or twice a year. Most of our clinic work and class work is done in the evening after office hours, so that it seldom interferes with office routine anyway, and satisfactory arrangements can be made for these special occasions. As far as I am concerned, I never have a bit of trouble getting time off for this phase of our Society activities. Doctor seems to appreciate the fact that I do not run away at the minute of 5:30 and that when there is something extra to be done, that thing comes first, and he is glad to allow me a little free time now and then. And I know that I am only one of our many, many girls who show that much interest in their jobs. There isn't a member of our Society who hasn't her heart in her work, striving toward the ideal of better service, and loyal service, to her employer and to his patients. But we are getting off the track!

Dr. F. C. Royce, President of the Second District Dental Society, presented his greetings and urged us to remember that it is within our power as hostesses in the dental office to create the tone and atmosphere of the office and advised us always to look pleasant and to smile.

Then we listened to a very interesting account of the experiences of the pioneer woman dentist of Brooklyn as told by Dr. L. Adele Cuinet herself. She related how she served her apprenticeship as assistant to a dentist for two years, until she was able to go to the Pennsylvania Dental College—since merged with the University of Pennsylvania—to study dentistry. She described the difficulties and obstacles that confronted her in entering college and while studying, and then of her problems when first starting in practice. Dr. Cuinet has a remarkable personality, is energetic and quick-witted despite her years, and serves as a fine example of the possibilities that lie before us.

Dr. Mary F. Gregory, the instructor of our First Aid Class, was also a guest and spoke briefly. She is an excellent teacher, making real first-aiders out of us. We have had most interesting meetings each Thursday evening for the past two months, and now we are on our tenth lesson. In another week we shall take our final examinations. Then you shall have tacked to one of your pages, Notebook, a beautifully engraved certificate which will proclaim to all that Janet Cross is a Registered First Aider—if she passes the test! I've really studied, though, as have the rest of the girls, and I am not afraid that I shall disgrace myself or the Society. But I'll have to tell you the rest of the story some other day, Notebook—it is 'way past midnight now. Good Night!



EXTRACTIONS



No Literature can have a long continuance if not diversified with humor—ADDISON

The atmosphere is that thin stuff composed of oxygen, nitrogen and soft coal.

(Clerk)—Do you want a shirt with stiff front and cuffs?

(Old Codger)—No, no! My doctor says I must avoid everything with starch in it.

It is strange that any woman can keep on loving a man after she sees his bare feet.

It's really awful the way the aluminum trust makes you pay a dime for a pan that once cost 25 cents.

The teacher was giving a talk to her pupils on the creation. Little John interrupted with the remark—"My father says we are descended from monkeys."

(Teacher)—That will do for you Johnnie. Your private family matters have no interest for this class.

EVERYBODY SAYS IT

J'aime! in French is sweet and strong,
Ich lieb! sounds good in German song,
Amo! reflects Italia's skies,
Agabo! the Greek lover cries.

Ljublj! is the Slavic blessing,
Ik Benun! keeps the Dutch boy guessing,
Karau-karah! the Bretons sigh,
Wasuke masu! all Geisha cry.

Jeg elsker! lisps the Danish lass,
Jag alsker! Swedish gallants gas,
Kocham! I hear in Polish ring,
Maitatzendent! the Basque maids sing.

I love! in English means the same,
I speak them all and have no "flame"!

TIMING IT

(Doctor)—How often does this pain come on?

(Lady Patient)—Every five minutes, doctor.

(Doctor)—And lasts how long?

(Lady Patient)—Oh, a quarter of an hour each time, at least.

A pleasing example of blank verse:

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A New York firm applied to Lincoln some years before he became President for information as to the financial standing of one of his neighbors. This was the answer:

Yours of the tenth received. First of all, he has a wife and baby; together they ought to be worth \$500,000 to any man. Secondly, he has an office in which there is a table worth \$1.50 and three chairs worth, say, \$10. Last of all, there is in one corner a large rat-hole, which will bear looking into.

Respectfully,

A. LINCOLN.

Little Ruth was visiting the country, and saw a pump for the first time in her life. After beholding it for a moment with astonishment, she ran to her daddy and told him: "There's an iron post, and water comes out of it when you shake hands with it."

It is said that men of science have no religion or belief in God. This is not always the case. An old professor in Princeton always took off his hat when he performed a scientific experiment, saying he was about to ask God a question.

AN EDITOR'S WARNING TO BORROWERS

Once upon a time a nickel-nurser sent his kid to borrow the neighbor's paper, and the kid upset a hive of bees and soon was covered with bumps. His father ran to help him and caught his chin on a clothes line and sprained his back and fell and broke a twenty-five dollar watch. The clothes pole fell over the car and smashed the windshield, and mother, rushing out to see what occasioned all the excitement, upset a five-gallon churn of cream into a basket of kittens, drowning all of them. The electric flatiron burned through the ironing board while she was out of the kitchen, setting fire to the house, and the firemen broke all the windows and chopped a hole in the roof. The baby ate a jar of pickles and got cholera morbus, and the doctor's bill was \$15. The daughter ran away with the hired man during the excitement, the dog bit a neighbor's kid and the calves ate the tails off of four night shirts on the clothes line.

Moral—Subscribe to your home paper. Don't borrow it!

DIETETICS and HEALTH

Speeding Up Sleep!

The sleep tests recently carried on at George Washington University show that "sleep has not only length but depth"—a distinction clearly recognized in popular speech—and that if we sleep deeply or "speed up our sleep mechanism," we can get along with fewer hours of it.

Most of us do not sleep efficiently, and thereby waste on slumber a lot of time which might be salvaged and added to the hours we give to work or play. Moreover, it appears, according to the findings—which are put forth as more persuasive than conclusive by the scientists who arrived at them—that sleep is a "form of intoxication."

Such are the implications of a report on the most elaborate laboratory researches yet made into the nature of sleep, says a writer in *N. Y. Times*. The tests consisted in having a group of persons stay awake for a period of three days and two nights, careful record being made of both physiological and psychological effects. Two of the group kept awake for eighteen hours longer, or for a total of four days and three nights. And at the end one of them made a better record in an army alpha mental test than he had made at the beginning of the period of wakefulness. Other results were equally surprising, though none was wholly unanticipated.

The doctors at George Washington found that sixty to seventy-eight hours of continuous wakefulness had no great physical effect upon the nine subjects. They were about as strong, though not so energetic, at the finish as at the beginning. Even their appearance suffered no striking change for the worse. Their eyes reddened a bit, their eyelids tended to droop, but otherwise their bodies showed little external effect. This was as true of the women as of the men. Those who were accustomed to sleeping six hours each night awoke fully refreshed in about ten hours after the tour of wakefulness ended. Those who usually slept from eight to nine hours awoke fully normal after ten to eleven hours in bed. This gives support to the deduction that sleep may be in much part a bad habit, as Socrates, Samuel Johnson and Thomas A. Edison have contended.

It was found that muscular activity is much more conducive than

mental activity to staying awake abnormally. The subjects got along best when they were playing games calling for physical contests and when engaged in such exercises as swimming and dancing. One of the young women swam across the Potomac River after being awake more than fifty hours.

One theory is that sleep results from cerebral anemia, or a lack of blood in the brain; the other that it results most often from an abundance of blood. Whatever change we may find in the blood supply to the brain can just as well be considered a consequence as a cause of sleep.

The scientists who made the tests in Washington seem to support the so-called chemical theory.

The changes found in every single case are similar to the changes found in various states of intoxication. When a drunkard becomes intoxicated, what does he do? Sleep; and as a rule he wakes detoxified. So in the case of our experiments the chemical and microscopical analyses pointed to a state of intoxication which was cured by a short period of sleep.

The intoxication which leads to sleep is caused evidently by an excess of toxins or poisons produced by muscular and nerve exertion. They are thrown off when the body and mind are at rest, and complete rest is achieved through sleep.

One difficulty in the way of this favored theory is that in many instances those who sleep most apparently have least mental and muscular activity during their waking state. Some of the most active persons give least time to sleeping.

This may be explained by the evident fact that it is not so much how long we sleep, as how fast our sleep mechanisms work while we are asleep. In short, sleep has not only length but depth.

If this assumption be true, the length of time that people sleep is very largely a habit. It might be possible to cause their sleep mechanism to work faster, just as by a series of reflexes we can make the salivary glands work faster.

The findings of Kohlschutter are cited to the effect that the average person sleeps 100 times as soundly during the first two hours as during the last hour.



FUTURE EVENTS

THE SIGMA EPSILON DENTAL FRATERNITY will hold its annual convention at the Hotel Astor, New York City, April 2-4, 1926.

NEW JERSEY STATE DENTAL SOCIETY

The fifty-sixth annual meeting of the New Jersey State Dental Society will be held at the Stacy-Trent Hotel, Trenton, N. J., April 14-17, 1926. The Society extends a cordial welcome to all ethical dentists.

PROGRAM

Essayists: Dr. Polk E. Akers, Chicago, Ill., *A New Simplified Method of Partial Denture Construction*; Dr. Percy R. Howe, Boston, Mass., *Diet in Relation to Health and Dentistry*; Dr. Fred D. Miller, Altoona, Pa., *The Displacement of Fractured Roots*.

Clinicians: Dr. Guy L. Haman, Reading, Pa., *Extracting for the General Practitioner*; Dr. Carlisle C. Bastian, New York, N. Y., *Porcelain Jacket Crowns and Removable Bridgework*; Dr. D. H. Baldwin, Peoria, Ill., *Gold Inlays with Porcelain Veneer*; Dr. M. T. Barrett, Philadelphia, Pa., *A Study of the Internal Anatomy of the Teeth*; Dr. M. J. Waas, Philadelphia, Pa., *Root Canal Technic*; Dr. Fred W. Lake, Boston, Mass., *Ultra-Violet Radiation in Oral Lesions*; Dr. John H. Gunter and Dr. LeRoy M. Ennis, Philadelphia, Pa., *Maxillary and Mandibular Cysts: X-Ray Interpretation*.

F. K. HEAZELTON, Secretary,
223 East Hanover St., Trenton, N. J.

THE PHILADELPHIA DENTAL COLLEGE ALUMNI will hold their 63rd annual reunion, Wednesday, April 21, 1926. Exercises will begin at 9 A. M. and continue all day.

There will be a number of good, instructive clinics. Some excellent papers will be read and discussed.

There will be a mid-day lunch with plenty of good fellowship, and a banquet in the evening.

FRANK S. FLUCK, Secretary,
2440 North 7th St., Philadelphia, Pa.

THE NEVADA STATE BOARD OF DENTAL EXAMINERS will hold its next examination at Reno, beginning Wednesday, May 12, 1926. All applications must be filed with the Secretary not later than May 1, 1926.

G. H. MARVEN, Secretary,
Reno, Nevada.

The Annual Convention of the ONTARIO DENTAL ASSOCIATION will be held at the King Edward Hotel, Toronto, May 17-20, 1926. An excellent practical program has been arranged. Dentists from points outside Ontario are cordially invited.

FRED J. CONBOY, Secretary-Treasurer,
Spadina House, Toronto 5, Ont.

The next meeting of the SOUTH DAKOTA BOARD OF DENTAL EXAMINERS will be held in Sioux Falls, S. D., beginning on Monday, June 28, 1926. All applications must be in the hands of the Secretary at least two weeks prior to the examination.

G. G. KIMBALL, Secretary,
Mitchell, South Dakota.

The next meeting of the AMERICAN DENTAL ASSISTANTS ASSOCIATION will be held in Philadelphia, Pa., August 19-21, 1926. Further details will appear at a later date.

JULIETTE A. SOUTHARD, *President*,
174 West 96th Street, New York, N. Y.

(Owing to a misunderstanding there appeared in the March issue a notice to the effect that the American Dental Assistants Association would meet *at the same time* as the American Dental Association in Philadelphia August 23-27, 1926. As a matter of fact, the meeting will be held August 19-21, therefore *before* the meeting of the American Dental Association.)

The next meeting of the AMERICAN DENTAL HYGIENISTS ASSOCIATION will be held in conjunction with the American Dental Association in Philadelphia, Pa., August 23-28, 1926.

Dental Hygienists make your plans now to attend this meeting.

LEONA M. MITCHELL, *Secretary*,
State Department of Health,
Harrisburg, Pa.

